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	255145	A. BUILDING _____ B. WING _____	10/24/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS CI MS #16103, CI MS #16239, CI MS #16272 & CI MS #16287 The State Agency (SA) conducted an annual recertification survey, along with complaint(s) MS #16287, MS #16239, MS #16103, and MS #16272, from 10/21/19 to 10/24/19. The SA substantiated MS #16272 for pain medication not available and administered per orders and cited F755 related to the complaint. The SA did not substantiate the other complaints, MS #16239-related to quality of care, missing clothing, infection control, and privacy; MS #16103-related to timely incontinent care and linen availability; and MS #16287-related to bedbugs. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited other deficiencies at F641, F645, F656, F690, F921, and F926. The facility census was 126 and the facility was licensed for 145 beds at the time of survey.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to accurately complete a Minimum Data Set (MDS) assessment for one (1) of 28 resident records reviewed, Resident #122.	F 641	F 641 1. Root Cause Analysis (RCA) was completed by Interdisciplinary Team (IDT) 10-28-19 and based on results Resident #122 Minimum Data Set Assessment	12/3/19

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

Electronically Signed | 11/14/2019

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F 641	Continued From page 1 Findings Include: Review of the facility's "Policies and Procedure" policy, revised 9/25/17, revealed to maintain all resident assessments completed within the previous 15 months in the resident's active clinical record, or in a centralized location that is easily and readily accessible. Each person completing a section or portion of MDS signs the Attestation Statement indicating accuracy/completeness. Review of the Discharge MDS, with an Assessment Reference Date (ARD) of 9/20/19, revealed "acute hospital" was documented as the discharge destination for Resident #122. On 10/23/19 at 4:23 PM, an interview with Licensed Practical Nurse (LPN) #5 revealed Resident #122 was admitted for rehabilitation. She stated the resident was never hospitalized during her stay at the facility. Record review of a physician's order, dated 09/20/19, revealed Resident #122 was discharged from the facility with all nursing home medications, except narcotics. Resident #122 left the facility in a personal vehicle with his/her spouse. On 10/24/19 at 11:06 AM, an interview with Registered Nurse (RN) #1, MDS/Care Plan Nurse, revealed Resident #122's discharge MDS was coded inaccurately for the discharge destination. On 10/24/19 at 11:50 AM, an interview with LPN #6/MDS Nurse revealed the code for Resident #122's discharge status was entered incorrectly	F 641	(MDS) with Assessment Reference Date (ARD) of 9-20-19 by MDS Coordinator, Registered Nurse to reflect discharge destination. 2. Quality Review of current Residents was conducted 11-8-19 by MDS Coordinator of Residents discharged within 30 days prior to 9-20-19 to ensure MDS reflects accurate discharge destination. Current residents requiring a discharge assessment have the potential to be affected. 3. Education was provided on 11-4-19 to both MDS Coordinators; Registered Nurse (RN) and Licensed Practical Nurse (LPN) by MDS Coordinator - Certified MDS Coordinator with emphasis on coding accuracy related to discharge destination per Resident Assessment Instruction (RAI) manual. Quality review was conducted 11-8-19 to ensure residents that discharged within 30 days prior to 9-20-19 last MDS assessments were coded accurately. Discharge MDS to be completed upon discharge with accurate discharge location coded. 4. Quality monitoring began on 11-5-19 and will be conducted three times a week for four weeks, then two times a week for four weeks and then monthly for two months by MDS Coordinator, Registered Nurse or MDS Coordinator, Licensed Practical Nurse to ensure discharge assessments are coded to reflect	

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F 641	Continued From page 2 for the discharge MDS; should have been to the community, not the hospital.	F 641	accurate discharge location. The findings of the Quality review will be reported in the monthly Quality Assurance Performance Improvement (QAPI) committee meeting and reviewed by the IDT. RCA will be used by the committee and updates made to the Performance Improvement Plan as indicated by the findings.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and	F 645		12/3/19

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F 645	Continued From page 3 (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by:	F 645		

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F 645	Continued From page 4 Based on staff interview, record review, and facility policy review, the facility failed to complete a Level II Preassessment Screening and Resident Review (PASARR), for a resident with mental illness diagnoses, for one (1) of 28 records reviewed, Resident #53. Findings include: A review of the provider manual (name of State provider for Preadmission Screenings) revealed Level II evaluations are mandated regardless of whether or not an individual is a recipient of Medicaid benefits. The Medicaid certification of the nursing facility, not the payment method of the individual, determines whether Level II evaluation is required. The Level II evaluation must occur prior to admission and whenever a resident experience a significant change in status. A review of the Pre-admission Screening (PAS), dated 5/20/19, revealed Resident #53 did not have a diagnosis of a major mental illness. A level II screen was not in the medical record. Review of the original admission face sheet, revealed Resident #53 was admitted 10/8/18, with a diagnosis of Schizoaffective Disorder. Review of the physician's orders, dated 5/24/2019, revealed the resident had diagnoses of Schizoaffective Disorder, Dementia, and Depression. A review of the "Diagnosis Report" revealed Resident #53 had diagnoses of Schizoaffective Disorder, Dementia with behavior, and other mixed anxiety disorders "present upon admission".	F 645	F645 1. Root Cause Analysis (RCA) was conducted 10-28-19 by the Interdisciplinary Team (IDT). Based on results the Social Services Director sent a Mississippi Pre Admission Screening and Resident Review (PASRR) Level II Change in status report to appropriately reflect resident #53's mental illness diagnoses 10-23-19. On 11-6-19, Ascend sent a Notice of Need for Level II PASRR Screen for Resident #53. 2. Quality review of current residents PASRR status began on 11-4-19 by Regional Director of Clinical Services and Medical Records Clerk to ensure a PAS/PASRR Prescreening was completed on current residents with mental illness diagnoses have the potential to be affected. 3. Education was conducted 11-8-19 with current Inter Disciplinary Team(IDT) members to include Clinical Liaison, by Divisional Director of Clinical Services with emphasis on completing a PAS/PASRR Prescreening and resident review for a resident with mental illness diagnoses. The facility is to assure that Serious Mentally Ill (SMI) receive appropriate pre-admission screenings according to the Federal/State Guidelines to ensure the residents with mental illness receive the care and services they need in the most appropriate setting.	

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F 645	Continued From page 5 On 10/22/19 at 3:07 PM, an interview with the Administrator revealed Resident #53 did not have any major mental illness upon admission. She stated the resident was diagnosed with major mental illnesses after admission. On 10/23/2019 at 3:35 PM, interview with the Social Worker/MDS Coordinator stated she believed Resident #53 would be exempted, due to Dementia. She also stated that the resident did not need a level II done; then stated a level II was submitted on 05/23/2019. On 10/23/2019 at 3:40 PM, an interview with the Social Worker/MDS Coordinator revealed they use (name of company) guidelines in reference to when a level II should be submitted. A review of the Minimum Data Set (MDS), with an Assessment Reference Data (ARD) of 5/31/2019, revealed documentation of Schizophrenia, Depression, and Anxiety Disorder diagnoses. On 10/23/19 at 3:45 PM, an interview with Registered Nurse #1 (RN)/MDS Nurse stated when MDS submission errors occur, it is corrected and resubmitted.	F 645	4. Quality monitoring began on 11-11-19 and to be continued by the Director of Nursing or Medical Records Clerk five times a week for four weeks, then three times a week for four weeks then monthly for two months to ensure residents with SMI receive appropriate pre-admission screenings according to the Federal/State guidelines. The findings of the Quality review will be reported in the monthly Quality Assurance Performance Improvement (QAPI) committee meeting and reviewed by the IDT. RCA will be used by the committee and updates made to the performance improvement plan as indicated by findings.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656		12/3/19

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F 656	Continued From page 6 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to implement the Comprehensive Care Plan related to Catheter Care, for one (1) of five (5)	F 656	F656 1. Root Cause Analysis (RCA) was conducted 10-28-19 by Interdisciplinary	

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F 656	Continued From page 7 care plans reviewed, Resident #15. Findings Include: A review of the facility's "Plans of Care" policy, revised 9/25/17, revealed the procedure is to develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. Resident #15 Review of Resident #15's Comprehensive Care Plan, with a focus of Elimination, implemented 3/18/19, with a target date of 11/15/19, revealed Resident #15 with altered bladder elimination and an intervention to perform catheter care, as ordered, per Nursing Aide. An observation on 10/21/19 at 10:45 AM, revealed Certified Nursing Aide (CNA) #1, assisted by CNA #2, performed catheter care on Resident #15. CNA #1 gloved and held the tubing approximately 12 inches up the tubing and away from the meatus. CNA #1, holding the tubing away from the meatus, wiped upwards, away from the body, with a soapy cloth and repeated this procedure while rinsing and drying the tubing. During an interview on 10/22/19 at 01:38 PM, CNA #1 stated the correct procedure would be to hold the catheter at the meatus when cleaning the tubing. CNA #1 stated that she couldn't remember how she held the tubing, but she thought she held it at the meatus, however, she was nervous. CNA #1 stated that she should have known how to do catheter care correctly.	F 656	Team (IDT) and based on results Resident #15's catheter care was re-conducted 11-14-19 by Director of Nursing to ensure appropriate technique was used. Certified Nursing Assistant #1 was educated by Director of Nursing on 11-14-19 performing catheter care with emphasis on appropriate technique to comply with Comprehensive Care Plan. 2. Five residents with catheters have the potential to be affected. 3. Competency Check off began on 11-13-19 by Director of Nursing, Charge Nurse, and Unit manager and will be conducted with current Certified Nursing Assistants with emphasis on using appropriate techniques in performing catheter care to carry out Comprehensive care plan with Certified Nursing Assistants annually, upon hire, and as indicated. In-service with Registered Nurses and Licensed Practical Nurses began on 11-11-19 by Director of Nursing, Charge Nurse, and Unit manager regarding Development and Implementation of Residents' Plan of Care. Staff will perform catheter care in a manner to carry out problems, goals and interventions of comprehensive care plan. Staff will develop and implement Residents' Plan of Care related to catheter care. 4. Quality Observation of Certified Nursing Assistants performing catheter	

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F 656	Continued From page 8 During an interview on 10/22/19 at 1:43 PM, CNA #2 revealed that she observed CNA #1 perform improper catheter care, by holding the catheter tubing away from the meatus, as she wiped up on the tubing. During an interview on 10/22/19 at 2:07 PM, the Director of Nursing (DON) stated CNA #1 should have held the catheter tubing at the meatus and not up the tubing. The DON stated that her holding the tubing away from the meatus could have caused trauma to the meatus as she wiped upward on the tubing. The DON stated CNA #1 didn't follow the care plan as related to proper catheter care. During an interview on 10/22/19 at 3:01 PM ,Registered Nurse (RN) #1 stated she expected problems, goals and interventions to be carried out by the staff from the Comprehensive Care plan. She stated that CNA #1 did not follow the Care Plan for catheter care if she did not complete the care correctly.	F 656	care began on 11-13-19 by Director of Nursing, Unit Manager, or Charge Nurse with a sample of three residents with catheters three times week for two weeks, then a sample of three two times a week for two weeks, then a sample of two monthly for two months. The findings of the Quality Review will be reported in the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting and reviewed by the IDT. RCA will be used by the committee and updates made to the Performance Improvement plan as indicated by findings.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must	F 690		12/3/19

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F 690	Continued From page 9 ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to prevent cross contamination during catheter care as evidence by incorrect cleaning technique of the catheter tubing for one (1) of five (5) catheter care observations, Resident #15. Findings Include: A review of facility policy titled "Catheter care, Urinary" revised 9/5/17, revealed the procedure for catheter care was to "clean the catheter tubing with soap and water, starting close to the urinary	F 690	F690 1. Resident #15's catheter care was conducted 11-14-19 by Director of Nursing (DON) to ensure appropriate technique to prevent urinary tract infections secondary to cross contamination. Director of Nursing assessed resident #15 for s/s of trauma from improper catheter care on 11-14-19 with no s/s of trauma present. 2. Five residents with catheters have the potential to be affected.	

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F 690	Continued From page 10 meatus, cleaning in a circular motion along its length for about four (4) inches, moving away from the body. Rinse well using the same motion". Resident #15 An observation on 10/21/19 at 10:45 AM, revealed Certified Nursing Aide (CNA) #1, assisted by CNA #2, entered the room to perform catheter care on Resident #15. CNA #1 gloved and held the tubing approximately 12 inches up the tubing and away from the meatus. CNA #1, holding the tubing away from the meatus, wiped upwards away from the body with a soapy cloth and repeated this procedure while rinsing and drying the tubing. During an interview on 10/22/19 at 1:38 PM, CNA #1 stated she was supposed to hold the catheter at the meatus when cleaning the tubing. CNA #1 stated that she couldn't remember how she held the tubing, but she thought that she held it at the meatus, however, she was nervous. CNA #1 stated she should know how to do catheter care correctly. During an interview on 10/22/19 at 1:43 PM, CNA #2 confirmed CNA #1 performed improper catheter care. CNA #2 stated she saw CNA #1 hold the catheter tubing away from the meatus as she wiped up on the tubing. During an interview on 10/22/19 at 2:07 PM, the Director of Nursing (DON) stated CNA #1 should have held the catheter tubing at the meatus, not up the tubing. The DON stated holding the tubing away from the meatus could have caused trauma to the meatus as the CNA wiped upward on the tubing.	F 690	3. Competency Check offs began on 11-13-19 and are to be conducted with current Certified Nursing Assistants with emphasis on using appropriate techniques in performing catheter care to prevent urinary tract infections secondary to cross contamination annually, upon hire, and as indicated. In-service began on 11-13-19 by the Director of Nursing, Charge Nurse, and Unit Manager regarding catheter care. 4. Quality Observation of Certified Nursing Assistants performing catheter care to be conducted by Director of Nursing, Unit Manager, or Charge nurse with a sample of three Residents with catheters three times a week for two weeks, then a sample of three two times a week for two weeks, then a sample of two monthly for two months. The findings of the Quality Observation will be reported in the monthly QAPI committee meeting and reviewed by the IDT. RCA will be used by the committee and updates made to the Performance improvement plan as indicated by findings.	

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COURTYARD REHABILITATION AND HEALTHCARE	501 SOUTH LOCUST STREET MCCOMB, MS 39648

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: MS #16272 Based on staff interview, record review, facility policy, and resident interview, the facility failed to obtain and provide Resident #61's pain	F 755	F755 1. Root Cause Analysis (RCA) was conducted by the Inter Disciplinary Team	12/3/19

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F 755	Continued From page 12 medication in a timely manner for one (1) of four (4) residents reviewed for pain. Resident #61 did not have Norco available for pain, as ordered by the physician, for nine (9) scheduled doses. Findings Include: A review of the facility's, "LTC Receiving Pharmacy Products and Services from Pharmacy", revised 10/31/16, revealed new orders for Schedule II controlled substances required a written prescription prior to dispensing, unless there is an emergency situation. An emergency situation is one in which the prescribing Practioner determines that immediate administration of the Schedule II controlled substance is necessary for proper treatment of the intended ultimate user. If the medication is needed before the next scheduled delivery, facility staff should indicate the exact time by which the medication is needed. Review of the Physician's Orders, for Resident #61, revealed Norco 10-325 milligram (mg) one (1) tab every eight (8) hours for pain. Record review of Resident #61's Controlled Narcotic Log for Norco 10-325 mg revealed the Norco 10-325 mg was last signed out 9/22/19 at 10:00 PM. The Log also shows Norco 10-325 mg #30 signed in for Resident #61 on 9/25/19, with the first dose signed out on 9/26/19 at 6:00 AM. This indicated the resident didn't receive Norco on 9/23/24 for three (3) doses, 9/24/19 for three (3) doses, and 9/25/19 for three (3) doses. (Total of nine (9) doses). Record review of the Medication Administration Record (MAR) for Resident #61 revealed no	F 755	10-28-19 and based on results. 2. Quality review of current residents with physician orders for pain medications was completed 10-23-19 by Director of Nursing to ensure current residents pain medications ordered by physician are available for administration. Resident #61 received her pain medication on 9-26-19 as ordered by the physician. 3. Education with licensed nurses 11-8-19 by Divisional Director of Clinical Services (DDCS)on this Federal regulation F755 with emphasis on ordering medications and ensuring medication is available for administration. Policy for providing pain medication in a timely manner review began on 11-8-19 with Licensed Nurses by the DDCS. New hires will be educated in orientation. Facility will provide routine emergency drugs and biologicals to its residents and provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident. 4. Quality monitoring began 11-11-19 and is to be conducted three times a week for four weeks, then two times a week for four weeks, then monthly by Director of Nursing, Charge Nurse, or Unit Manager of medication availability to ensure physician ordered medications are available for administration. The findings	

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F 755	Continued From page 13 documentation for Norco 10-325 milligram (mg) on 9/23/19 at 2:00 PM and 10:00 PM; 9/24/19 at 6:00 AM, 2:00 PM, and 10:00 PM; and 9/25/19 at 6:00 AM. During an interview on 10/21/19 at 11:25 AM, Resident #61 stated she ran out of her pain medication for about three (3) days. She stated the nurses told her the pharmacy needed a signed script for the medication, so they had to wait to get a doctor to sign a new script. She stated she was upset because she was hurting so bad. Resident #61 stated since the issue was cleared up, she hasn't had any problems with getting the pain medication and she's okay. During a telephone interview on 10/21/19 at 3:23 PM, a Pharmacy Representative stated that the pharmacy's records revealed that Resident #61's Norco 10-325 mg #90 was delivered to the facility on 8/19/19, and on 9/25/19 #45 was delivered to the facility. Review of a delivery receipt revealed Norco 10-325 mg was delivered to the facility for Resident #61 on 8/19/19, and 9/25/19. During a phone interview on 10/21/19 at 5:08 PM, Licensed Practical Nurse (LPN) #2 stated Resident #61 did go without her pain medication for one (1) - two (2) days. She stated that it was on her weekend to work and she gave the 10:00 PM dose on Sunday night 9/22/19, but there were none for Monday morning. LPN #2 stated that she returned to work on Wednesday 9/25/19, and Resident #61 still did not have any Norco, so she obtained a hard script from the facility's Physician's Assistant (PA) for the Norco. LPN #2 stated that when she spoke to the PA to obtain the new prescription, he stated that nobody had called him over the weekend for a hard script or	F 755	of the Quality Review will be reported in the monthly Committee meeting and reviewed by the IDT. RCA will be used by the committee and updates made to the performance improvement plan as indicated by findings.	

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F 755	Continued From page 14 for a substitute. During an interview on 10/22/19 at 8:58 AM, the Physician's Assistant revealed that he was never made aware of Resident #61 being without her Norco at any time. During a phone interview on 10/22/19 at 10:00 AM, LPN #3 revealed Resident #61 did not have Norco in the building for her shift on 9/23/19 for the 10:00 PM, 9/24/19 - 6:00 AM, 9/24/19 - 10:00 PM, and 9/25/19 - 6:00 AM doses. LPN #3 stated she reported not having the medication to Registered Nurse (RN) #2 the first night, and then RN #3 the second night. LPN #3 stated to her understanding they do have an E-kit, but they have to contact the pharmacist and the pharmacist has to contact the physician to be able to get into the box. LPN #3 stated that RN #2 tried to call the Physician's Assistant, without an answer. LPN #3 stated after she reported it the first night, she thought the Norco would come in with the medication order around 11:00 PM, but it didn't, and when she returned to work the next day, she thought it would be there, but it wasn't, so that's when she reported to RN #3. She stated she also reported it the next morning to the oncoming nurse. During an interview on 10/22/19 at 10:12 AM, LPN #1 stated she didn't remember if the medication (Norco) was in the building or not. She stated if she would have noticed the medication was not there, she would have called the pharmacy to see if Resident #61 had any on backup that could have been sent. She further stated if the medication was a narcotic, she would call the doctor for a hard script and get the medication into the facility. LPN #1 stated she	F 755		

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F 755	Continued From page 15	F 755		

worked 9/23/19 and 9/24/19, and she just didn't remember calling the pharmacy or the doctor to get a script. She stated she didn't remember the resident complaining about not getting pain medication. LPN #1 stated they have an E-kit and a code was needed to call the doctor and the pharmacist. LPN #1 stated they have an after-hour backup pharmacy, (name) and they will come out at night. LPN #1 stated she gave the resident Tylenol on 9/23/19 at 4:45 PM, 9/24/19 at 8:45 AM, and 9/24/19 at 6:15 PM.

During an interview on 10/22/19 at 10:20 AM, RN #2 revealed she remembered on 9/24 or 9/25, that Resident #61 did not have her pain medication. RN #2 stated Resident #61 called her to come to her room and the resident reported she didn't have her pain medication. RN #2 stated she called the Medical Director and left him a message and even called him two (2) or three (3) times with no answer from him. She stated she even called his house phone. RN #2 stated that she didn't know the process of getting into the E-kit, but she just usually called the physician with what she needed. RN #2 stated they offered Resident #61 some Tylenol and she refused it. RN #2 stated if it had been reported to her earlier in the day, she would have gotten a script, because the PA was in the building earlier that day. RN #2 stated she remembered the PA came into the building on 9/25/19, and LPN #2 got a hard copy from him and got Resident #61's Norco. RN #2 stated that she knew Resident #61 well and she needed her pain medication.

During an interview on 10/22/19 at 10:44 AM, RN #3 stated all she could remember was that Resident #61 didn't have her medication on 9/23/19, and she reported it to the morning

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F 755	Continued From page 16 nurses on 9/24/19. She stated Resident #61 was complaining that she needed her pain medication. RN #3 stated they offered her Tylenol and she refused at first, but then took it. RN #3 stated she called the Medical Director, who is Resident #61's physician, on 9/24/19, and left a message that Resident #61 needed a hard script sent to pharmacy for her pain medication, that she was out, and the physician texted back the word "ok". RN #3 stated that she didn't work 9/24/19 or 9/25/19, but came back on 9/26/19, and Resident #61 had her medication at that point. During an interview on 10/22/19 at 1:20 PM, the Administrator revealed getting the medication for Resident #61 just fell through the crack. The Administrator stated the nurses did not follow through with the process to obtain Resident #61's pain medication in a timely manner, but she was glad they gave her something until it was obtained. During an interview on 10/22/19 at 3:14 PM, the Medical Director revealed he did not have a memory regarding Resident #61 running out of pain medication. The Medical Director stated the nurses should have been persistent in contacting someone to get a hard script, or to get a substitute pain medication, until they received the Norco in the facility. The Medical Director stated, "I think Resident #61 receiving Neurontin and Tylenol is what helped her maintain a decent pain level without the Norco". The Medical Director stated he thought there was a way the nurses could call the pharmacy and get an emergency supply of medication, but he wasn't sure what the facility's process was.	F 755		
F 921	Safe/Functional/Sanitary/Comfortable Environ	F 921		12/3/19

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F 921 SS=E	Continued From page 17 CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to have lids sealed on the Biohazard Trash Cans for Seven (7) of seven (7) trash cans in the Biohazard Room, where staff placed medical waste. Findings include: According to the Policy and Procedure "Storage of Biohazardous Waste", revised 9/1/17, revealed: Policy: Biohazardous waste should be stored in a manner that is safe, effective and in compliance of all facility, local, state and federal laws, rules and regulations. Policy Statement: Medical waste will be handled and disposed of safely and in accordance with regulator requirements. Disposable items contaminated with excretions or secretions from residents believed to be infectious must be placed in plastic bags and sealed, and either decontaminated with bleach/EPA registered germicidal or stored in appropriate container until removal from the premises. On 10/23/2019 at 4:22 PM, observation revealed there were no lids on the seven (7) Biohazard trash cans in the Biohazard Room. On 10/23/2019 at 4:22 PM, an interview with the Maintenance Person revealed trash can lids should be placed on the biohazard trash cans.	F 921	F921 1. Root Cause Analysis (RCA) was conducted by the Inter Disciplinary Team (IDT) and based on the results biohazard trash cans in biohazard room with lids 10-24-19 by Maintenance Supervisor. 2. Current residents have the potential to be affected. 3. Education with current staff began on 11-11-19 by Maintenance Supervisor on Federal regulation F921(Safe/Functional/Sanitary/Comfortable Environment) and the facility policy regarding storage of biohazard waste with emphasis on keeping lids secured on biohazard containers in biohazard room. The Facility will handle and dispose of medical waste safely. Disposable items contaminated with excretions or secretions from residents believed to be infectious, must be placed in plastic bags and sealed. 4. Quality monitoring of biohazard waste began on 11-11-19 by the Maintenance Supervisor or the Director of Nursing five times a week for four weeks, then three times a week for four weeks, then monthly	

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F 921	Continued From page 18 The Maintenance person stated the (company) picks up the biohazard waste weekly. On 10/24/2019 at 8:00 AM, an interview with the Administrator revealed the trash can lids should be placed on the biohazard trash cans; if there is trash in them. The Administrator was referred to the regulation, when asked since the room is only for Biohazard material, does the trash cans need the lids placed on them.	F 921	for two months to ensure disposable items contaminated with excretions or secretions believed to be infectious are placed in plastic bags, and sealed with lid on biohazard container. The findings of the Quality monitoring will be reported in the monthly Quality Assurance Performance Improvement (QAPI) committee meeting and reviewed by the IDT. RCA will be used by the committee and updates made to the Performance Improvement Plan as indicated by the findings.	
F 926 SS=E	Smoking Policies CFR(s): 483.90(i)(5) §483.90(i)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account nonsmoking residents. This REQUIREMENT is not met as evidenced by: Based on interview, observation, record review, and facility policy review, the facility failed to provide a safe smoking environment as evidenced by plastic trash cans and plastic bags were used in the smoking area for cigarette butt disposal, for three (3) of four (4) observations during survey. Findings include: A review of the "Smoking" Policy, dated, revealed: The Center will provide a safe, designated smoking area for residents. Smoking is only allowed in designated areas and oxygen is not permitted. The Center will have safety equipment	F 926	F 926 1. Root Cause Analysis (RCA) was conducted by the Interdisciplinary Team (IDT) on 10-28-19 and based on results plastic trash cans and plastic liners were removed from smoking porch on 10-24-19 by the Executive Director. 2. Current residents that smoke have the potential to be affected. 3. Education with current Housekeeping and Maintenance staff began on 11-08-19 conducted by Executive Director	12/3/19

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F 926	Continued From page 19 available in designated smoking areas including: smoking blankets, smoking aprons, a fire extinguisher and non combustible self-closing ashtrays. Procedure: 7. Metal containers with self-closing cover devices, into which ashtrays can be emptied, shall be readily available to all areas where smoking is permitted. On 10/21/19 at 11:17 AM, an observation in the smoking area revealed a plastic trash container and plastic trash bag, with cigarette butts noted in the plastic container. On 10/23/19 at 2:57 PM, an interview was conducted with Resident #42, whom reported he is aware of the designated smoking areas, staff is available while smoking, and he does not keep his own cigarettes, the staff hold onto their cigarettes. On 10/23/19 at 3:12 PM, an observation in the smoking area revealed a plastic trash container/plastic trash bag, with cigarette butts noted in trash container. On 10/23/19 at 3:57 PM, an interview with Housekeeping Staff #1, revealed Housekeeping cleaned the smoking area two (2) times a day and emptied the trash bags. On 10/24/19 at 9:47 AM, an interview and observation, with the Administrator, revealed the trash container in the smoking area, with plastic bags, and cigarette butts. The Administrator stated there should be no plastic bags in the smoking section.	F 926	regarding safe smoking trash cans or liners in smoking areas. The facility will provide a safe smoking environment. 4. Quality Observation of smoking areas began on 11-08-19 and will be conducted by Executive Director or Maintenance Supervisor five times a week for four weeks, then three times a week for four weeks, then monthly for two months to ensure a safe smoking environment. The findings of the Quality review will be reported in the monthly Quality Assurance Performance Improvement (QAPI) Committee Meeting and reviewed by the IDT. RCA will be used by the committee and updates made to the performance improvement plan as indicated by findings.	

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe	K 321		12/3/19

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

Electronically Signed | 11/15/2019

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K 321	Continued From page 1 Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to properly protect hazardous areas as per NFPA 101 section 19.3.2.1.2. and NFPA 101 section 8.4.2 This deficiency affected one (1) of six (6) smoke compartments and 18 of 126 residents in the facility on the day of survey. Findings Include: During the building inspection on October 24, 2019 at 10:40 AM, observation revealed unsealed and improperly installed vent fans in the ceiling in B Hall Storage and B Hall Central Supply rooms of the facility. These rooms were incapable of resisting the passage of smoke throughout the facility and the vent fan shall be vented the roof, not in the attic of the facility. The administrator was made aware of the issue during the exit conference.	K 321	1. The unsealed and improperly installed vent fans in the ceiling in B hall storage and B hall central supply will be corrected. 2. Additional vent fans will be reviewed for being properly sealed and installed. 3. The Executive Director educated the Maintenance director on the importance of NFPA 101 Hazardous area- enclosure specific to properly sealed and installed vent fans, and will continue to monitor in accordance with NFPA standards. 4. Any findings will be reported to the monthly QAPI committee for further review.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by:	K 345		12/3/19

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COURTYARD REHABILITATION AND HEALTHCARE	**501 SOUTH LOCUST STREET MCCOMB, MS 39648**

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K 345	Continued From page 2 Based on observation, the facility failed to properly maintain the fire alarm system in accordance NFPA 72. This condition affected all 126 residents in the facility at the time of survey. Findings include: On October 24, 2019 at 10:30 am, observation a dialer issue "trouble signal" on the fire alarm panel of the facility. The fire alarm system worked properly during testing and was capable of notifying emergency services.	K 345	1. The dialer issue "trouble signal" on the fire panel was corrected by a qualified vendor. 2. There is only one fire alarm panel with a dialer issue "trouble signal" in the facility, therefore no additional reviews were needed. 3. The Executive Director educated the Maintenance Director on the importance of the NFPA 101 fire alarm system - testing and maintenance specific to proper service of the fire alarm panel shows "trouble signals," and will continue to monitor in accordance with NFPA standards. 4. Any findings will be reported to the monthly QAPI Committee for further review.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.	K 363		12/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255145	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/24/2019**

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K 363	Continued From page 3 Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and testing, the facility failed to properly protect corridor openings as directed by NFPA 101 section 19.3.6.3.5. This deficiency affected two (2) of six (6) smoke compartments and 36 of 126 residents in the facility during the survey. Findings Include: On October 24, 2019 between 10:30 AM and 11:35 AM, observation revealed the following corridor doors of the facility were incapable of closing properly to positive latching position:	K 363	1. The doors to the linen closets on B and C halls, the kitchen door of the facility, and the bi-fold doors on the B hall closets were made to properly close and positively latch. 2. Additional corridor doors were reviewed for proper closing and positively latching. 3. The Executive Director educated the Maintenance Director on the importance of NFPA 101 Corridor - Door specific to corridor doors properly and positively	

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	255145	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/24/2019**

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K 363	Continued From page 4 1. Linen Closets on the B and C Halls of the facility 2. The Kitchen door of the facility 3. Bi-fold doors on the B Hall closets The administrator was made aware of the problem during the exit conference.	K 363	latching, and will continue to monitor in accordance with NFPA standards. 4. Any findings will be reported to the monthly QAPI committee for further review.	
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to properly protect all the generator's required components as directed by NFPA 110 section 5.6.6 and NFPA 99 section 6.4.1.1.17. This deficiency had the potential to affect all 126 of the residents in the facility at the time of survey. Findings Include: On October 24, 2019 at 10:50 AM, observation and testing revealed an inoperable remote annunciator for generator of the facility. The remote annunciator unit did not have power to the generator.	K 916	1. The remote annunciator for the facility's generator will be repaired by a qualified vendor. 2. There is only one remote annunciator for the facility's generator, therefore no additional reviews were needed. 3. The Executive Director educated the maintenance director on the importance of the NFPA 101 electrical systems - essential electrical system specific to maintaining proper function of the facility's generator annunciator panel, and will	12/20/19

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	255145	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/24/2019**

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K 916	Continued From page 5	K 916	continue to monitor in accordance with NFPA standards. Work order placed 10/24/19 and repairs completed by 12/03/19. Copies of work order and invoice sent on 12/19/19. 4. Any findings will be reported to the monthly QAPI Committee for further review.	

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E 000	Initial Comments ********** Survey conducted on 10/24/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

Electronically Signed | 11/15/2019

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 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.