STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255145	A. BUILDING _____ B. WING _____	C 09/30/2021

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

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F 000	INITIAL COMMENTS The State Agency (SA) conducted a complaint investigations (CI) MS #17609 and CI MS #17315, from 9/29/21 through 9/30/21. The facility was found not to be in compliance with requirements for participation in Medicare and Medicaid. The SA substantiated CI MS #17609 for improper technique during incontinent care that could cause the spread of infection and cited F880. The SA substantiated CI MS #17315 for verbal abuse and cited F600.The census at the time of the survey was 114, and the facility held a license for 140 beds.	F 000		
F 600 SS=D	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 record review and interviews the facility failed to prevent verbal abuse for one (1) of four (4) sampled residents. Resident #1. Findings Include:	F 600	1. Root Cause Analysis was conducted on November 10, 2020 by the Quality Assurance and Performance Improvement (QAPI) Committee consisting of Executive Director (ED),	11/12/21

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

Electronically Signed | 10/29/2021

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F 600	Continued From page 1 Record review of facility Policies and Procedures titled "Abuse, Neglect, Exploitation & Misappropriation", with Revision Date of 11/28/17, revealed "It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse...Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance regardless of age, ability to comprehend or disability". On 9/29/21 at 10:30 AM, an interview with the Director of Nurses (DON) revealed she had reported to the State Agency (SA) an incident in which a Certified Nurses Assistant (CNA) made disparaging statements within the hearing of a resident. The DON stated she had been notified by Resident #1's Responsible Party (RP) that a CNA standing outside the resident's room had made the statement "He should have killed himself". Record review of the facility's investigation revealed a statement dated 11/10/20, signed by the DON and signed by Resident #1, which stated Resident #1 had identified the CNA and reported she stated, "He should have killed himself when he wanted to". Record review of the facility's investigation revealed a Witness Statement dated 11/10/20 and was signed by Licensed Practical Nurse (LPN) #1 in which she stated "CNA #1 came up and she was laughing. She stated (Resident #1) just came back if he wanted to kill himself, he should have just did it."	F 600	Director of Nursing (DON), MDS Coordinator, Unit Manager, Social Services, Human Resources Coordinator, and Medical Records Coordinator, and based on findings: Resident #1 was assessed for injury on November 10, 2020 by Director of Nursing. No injuries noted. Certified Nursing Assistant (CNA #1) was suspended by the Director of Nursing on November 10, 2020 and as a result of investigation was terminated on November 10, 2020 by Director of Nursing. 2. Interviews with current residents with a BIMS of 13 or higher was conducted by Director of Nursing on November 11 and 13, 2020. Current residents could be affected by deficient practice. 3. Education was conducted with Executive Director and Director of Nursing by the Regional Director of Clinical Services on November 10, 2020 on Abuse and Neglect with emphasis on verbal abuse. Education with current facility staff was initiated on November 10, 2020 by the Director of Nursing on Abuse and Neglect with emphasis on verbal abuse. Directed In-service to be conducted with all staff on November 4 and 8, 2021 by Regional Director of Clinical Services on Abuse and Neglect with emphasis on	

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F 600	Continued From page 2 Record review of "VERIFICATION OF INVESTIGATION" dated 11/10/20 and signed by the Administrator and DON revealed the facility performed an investigation into the complaint first reported by the wife of Resident #1 on 11/10/20 at 10:00 AM. The "VERIFICATION OF INVESTIGATION" summary and outcome of investigative findings revealed "Nurse stated that the CNA, (CNA #1) did make an inappropriate comment. ..Based upon resident's description and statement ...employee's behavior was inappropriate ...CNA's employment with the facility was terminated". On 9/30/21 at 4:30 PM, an interview with the Responsible Party (RP) of record for Resident #1 revealed on 11/10/20 she reported to the DON that her husband had reported to her the CNA stated "He should have killed himself" within hearing of Resident #1. Record review of Resident #1's Face Sheet revealed he was admitted by the facility on 9/22/20 and had diagnoses of Urinary Tract Infection and Atherosclerotic Heart Disease. Record review of Five Day Assessment Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/09/20 Brief Interview for Mental Status (BIMS) revealed Resident #1 had a BIMS score not listed, but the social worker that administered the interview noted all correct answers and no memory problem and categorized Resident #1 as "Cognitively Intact". On 9/30/21 at 5:50 PM, an interview with the Administrator revealed she had been made aware of the allegation on 11/10/21, the allegation had been substantiated by the facility through	F 600	verbal abuse. Newly hired staff to be educated on Abuse and Neglect in orientation by Director of Nursing or Human Resources Coordinator. 4. Director of Nursing or Assistant Director of Nursing to conduct ongoing quality monitoring of staff through observation and resident or resident representative interviews for 5 residents 5 X weekly for 2 weeks then 3 X weekly for 2 weeks then monthly x 3 months and as needed (PRN) to ensure residents are free from verbal abuse. Quality monitoring was initiated on November 01, 2021. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee on November 12, 2021 and reviewed monthly x 3 months. Schedule will be revised based on findings. 5. Corrective action will be completed by November 12, 2021.	

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F 600	Continued From page 3 immediate investigation.	F 600		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		11/12/21

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F 880	Continued From page 4 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff and Responsible Party interview, record review and facility policy review, the facility failed to provide incontinent care in a manner to prevent the possible spread of infection for one (1) of three (3) sampled residents reviewed for incontinent care. Resident #4.	F 880	1. Root Cause Analysis was completed on September 29, 2021 by the Quality Assurance and Performance Improvement (QAPI) Committee consisting of Executive Director (ED), Director of Nursing (DON), Assistant Director of Nursing (ADON), MDS Coordinator, Unit Manager, Social	

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F 880	Continued From page 5 Finding included: Record review of the facility's "Policies and Procedures Subject: Perineal Care" dated 11/14/16 stated "Policy: Perineal care will be provided as needed in order to keep the resident clean and free of infection ...Wash perineal area with ...disposable wipes, wiping front to back" Record review of the National Nurse Aide Assessment Program (NNAAP) Mississippi Nurse Aide Candidate Handbook" revealed the standard of practice for perineal care included "critical element... step #8... Washes genital area, moving from front to back, while using a clean area of the washcloth for each stroke". On 9/29/21 at 6:30 PM, an observation of incontinent care performed by Certified Nurse Assistant (CNA) #2 and CNA #3 revealed while washing genital area of Resident #4, CNA #2 moved the disposable washcloth from back to front on the third and fourth stroke. The CNAs turned Resident #4 onto her side to clean the rectal area and left fecal matter visible on the genital area of Resident #4. After Resident #4 was turned onto her side, CNA #2 washed the rectal area and moved from back to front on the third wipe, then wiped from front to back with the same area of the disposable washcloth. On 9/29/21 at 6:44 PM, the State Agency (SA) asked the Director of Nurses (DON) and the Assistant Director of Nursing (ADON) to assess Resident #4 for cleanliness because the SA had observed fecal matter on the genital area of Resident #4 following the completion of perineal care by CNA #2 and CNA #3. The Director of Nurses (DON) and Assistant Director of Nurses	F 880	Services, Human Resources Coordinator, and Medical Records Coordinator and based on results: Resident #4 was provided incontinent care by Certified Nursing Assistant (CNA) on September 29, 2021 to remove feces from genital folds. CNA #2 and CNA #3 was educated by Director of Nursing (DON) on September 29, 2021 on Infection Control with emphasis on providing incontinent care in a manner to prevent the spread of infection. 2. Quality review of a sample of 12 incontinent residents was conducted by DON on September 29 and 30, 2021 to ensure incontinent care was provided in a manner to prevent the spread of infection. Current Residents requiring incontinent care could be affected by the deficient practice. 3. Competency check offs will be conducted by DON and ADON with current CNAs and licensed nurses on providing incontinent care in a manner to prevent the spread of infection. Competency check offs were initiated on October 27, 2021. Competency check offs will be completed by November 12, 2021. Education initiated for all direct care staff by ADON on October 27, 2021 with the use of online education modules through Relias Learning on Infection Control with	

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F 880	Continued From page 6 (ADON) checked Resident #4 for cleanliness and identified the substance present on and in the folds of the genitalia of Resident #4 as "bowel movement". Record review of the Admission Record for Resident #4 revealed she had been admitted by the facility on 5/14/21 with diagnoses of Pressure Ulcer of Sacral Region, Stage 4, Hypothyroidism and Hyperlipidemia. Record review of the Resident's Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) 8/21/21 revealed a Brief Interview for Mental Status (BIMS) score of 6 which indicated severe cognitive impairment. Further review of the MDS revealed Resident #4 was "always incontinent" for bowel and bladder elimination and required "extensive assistance" for toilet use/cleansing after elimination. On 9/30/21 at 11:10 AM, during an interview with the DON, she confirmed the substance present on and in the folds of the genitalia of Resident #4 as "bowel movement". She stated she did not believe the resident had had another bowel movement between the performance of perineal care for Resident #4 by CNA #2 and CNA #3. She stated "it was left there" and confirmed the perineal care should result in complete cleaning of the resident's genital area according to current standards of practice and facility policy and procedures. When the SA notified the DON that CNA #2 had cleaned Resident #4 from back to front upon multiple strokes while washing the genital and rectal areas and used the same area of the disposable washcloth, the DON stated, "that's a problem". The DON confirmed that wiping the wrong direction (back to front), using	F 880	emphasis on providing incontinent care in a manner to prevent the spread of infection. New hires will have competency check offs completed with DON or ADON upon hire. 4. Director of Nursing or Assistant Director of Nursing to conduct ongoing quality monitoring through observation of incontinent care, with a sample of 10 residents, 5 x weekly for 2 weeks, then 3 x weekly for 2 weeks, then monthly x 3 months and as needed (PRN) as indicated to ensure staff are providing incontinent care in a manner to prevent the spread of infection. Quality monitoring was initiated on November 1, 2021. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee on November 12, 2021 and reviewed monthly x 3 months. Schedule will be revised based on findings. 5. Corrective action will be completed by November 12, 2021.	

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F 880	Continued From page 7	F 880		

the same surface of the disposable washcloth, and leaving fecal matter (bowel movement) on the resident's genital area could lead to urinary tract infection and did not meet current standards of care.

On 9/30/21 at 3:25 PM, an interview with the Responsible Party (RP) for Resident #4 revealed she felt the staff could do a better job with hygiene.

On 9/30/21 at 3:37 PM, an interview with CNA #2 revealed she was aware she had "made mistakes" while providing perineal care for Resident #4 on 9/29/21 at 6:30 PM. She stated, "I do know how to do it right". When asked her what she should have done differently she was able to list the following: "more cleaning, wipe front to back and use a clean (disposable) wipe every time". She stated she knew the result of not following correct procedure could lead to urinary tract infections.

On 9/30/21 at 3:50 PM, an interview with CNA #3 she confirmed she knew not following correct procedure could cause urinary tract infections.