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	255212	A. BUILDING _____ B. WING _____	C 06/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

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F 000	INITIAL COMMENTS The State Agency (SA) conducted a complaint survey investigating MS CI #17402 from 6/7/2021 through 6/9/2021. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA substantiated the complaint and deficiencies were cited at F609 related to reporting and F726 related to competent nursing staff. The facility's census was 49 at the time of the survey.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 609		7/2/21

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

Electronically Signed | 07/02/2021

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.

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accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:

Based on staff interviews, family interview, facility policy review and record review, the facility failed to notify the State Agency (SA) of an allegation of neglect for one (1) of five (5) residents reviewed. Resident #1.

Findings include:

Review of facility policy titled, "Unusual Incidents - State Agency", dated 11/4/2004, revealed, "It is the policy of this facility that unusual incidents must be reported timely to the proper authorities. Definition of unusual incident - An unusual incident is an unexpected occurrence or accident resulting in death, life threatening or serious physical injury to a resident or the abuse of a resident."

An interview by phone with Resident #1's Resident Representative (RR), on 6/7/2021 at 3:10 PM, revealed her concerns of her father's care in the facility. She stated Resident #1 was admitted to the hospital from the facility and she was alarmed when she saw how thin her Dad appeared. She stated that the Resident's weight on admission to the hospital was 128 pounds, and his normal weight was between 170 - 180 pounds. She stated he had tested positive for COVID-19 upon admission to the hospital. She notified the facility and told them, "My father has been neglected by your facility." She stated she informed the DON (Director of Nursing) that her father had a massive weight loss and she wanted

1. The facility will ensure that all alleged allegations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown origin and misappropriation of resident property will be reported immediately to Administrator and Director of Nursing. Administrator or Director of Nursing will then immediately report allegations to the Mississippi State Department of Health within appropriate time frame. Regional Director of Operations in-serviced Administrator and Director of Nursing on 6/25/21 on reporting allegations immediately to the State Survey Agency. All allegations will be investigated by Administrator and/or Director of Nursing and a report of full investigation will be sent into the Mississippi State Department of Health upon conclusion with corrective actions.

2. All residents have the potential to be affected by the alleged deficient practice.

3. The Director of Nursing will in-service staff regarding abuse and neglect prevention plan and immediately reporting abuse/neglect or suspected abuse/neglect to direct supervisor who will then report to Administrator or Director of Nursing. Inservice training will be completed by 7/2/21. All allegations of abuse/neglect or suspected abuse/neglect will be

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F 609	Continued From page 2 the facility to investigate and determine what happened to him and why had no one noticed his decline. She stated that before COVID-19, the Resident's wife and other family members would go to see him daily. She stated they would assist him with meals and other care. Once COVID started, the family could no longer go into the facility to check on him but they could window visit and FaceTime, but they could not get close to him or see how his weight was decreasing. The family was relying on the staff to care for him.She confirmed he was in the hospital from 7/23/2020 - 7/28/2020 and when he was discharged, he had to return to the same facility due to his positive COVID-19 status.He passed away on November 10, 2020. An interview with Administrator on 6/9/2021 at 2:30 PM, revealed she was unable to find any documentation from the previous administration that this incident was reported after the RR had made the allegation of neglect. The Administrator confirmed the facility failed to notify the proper authorities of the investigation into the allegation of neglect of this Resident. An interview with the Director of Nursing (DON) on 6/9/2021 at 2:32 PM, revealed he did not report this allegation of neglect to the State Agency (SA) and he was unable to determine the facility reported the allegation of neglect prior to his employment. The DON confirmed the facility is responsible to notify proper agencies for any allegation of abuse or neglect. The DON confirmed the facility failed to notify the SA of the allegation of neglect of a resident. Record review of the Admission Record revealed that Resident #1 was admitted to the facility on	F 609	thoroughly investigated by Administrator and/or Director of Nursing. Social Services Director will oversee the Grievance Process beginning 6/25/21 and will report any abuse/neglect grievances to Administrator or Director of Nursing immediately for investigation. 4. Newly hired staff will be educated in orientation regarding abuse/neglect policy and prevention plan and reporting abuse or suspected abuse immediately to appropriate parties. The Director of Nursing will inservice current staff to be completed by 7/2/21 regarding abuse/neglect reporting and will continue training as needed thereafter. Social Services Director will report any grievances to Administrator daily in stand-up meeting to ensure facility compliance with reporting allegations. Social Services Director will interview a random sample of six residents, three from each hall, weekly beginning 6/25/21 x four weeks and then as needed thereafter to assess and ensure residents are safe from abuse/neglect. Social Services Director will report findings to the Quality Assurance and Performance Improvement Committee monthly and as needed for review.	

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F 609	Continued From page 3 4/4/2019. Resident #1's diagnoses included Dementia, Chronic Obstructive Pulmonary Disease, Hypertension, Anxiety Disorder, Vitamin Deficiency, Anemia, Anorexia, Dysphagia Following Unspecified Cerebrovascular Disease; Transient Cerebral Ischemic Attack. Record review of Minimum Data Set (MDS), Section C - Cognitive Patterns, dated 10/26/2020 revealed resident with a Brief Interview for Mental Status (BIMS) score of "0" indicating severe cognitive deficits.	F 609		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.	F 726		7/2/21

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F 726	Continued From page 4 §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on resident and family interviews, staff interviews, record review, and facility policy review, the facility failed to establish a consistent method of weighing a resident and accurately monitoring the resident's weight for one (1) of five (5) residents. Resident #1 Findings include: Review of facility policy titled, "Weight Loss Prevention", dated 12/27/2017, revealed it is the policy of this facility to prevent weight loss if avoidable and if unplanned. A Malnutrition Risk Assessment will be completed for each resident upon admission, readmission, with significant change in condition, and at least quarterly." Review of facility policy titled, "Evaluating Weight", dated 9/27/2013, revealed, "Each resident's weight will be evaluated monthly, as indicated by the resident's condition, or as ordered by the physician. Unintentional weight loss is any loss other than planned weight loss." Review of facility policy titled, "Weights: Obtaining and Documenting", dated 9/27/2013, revealed, "Each resident will be weighed monthly or as indicated by their condition unless contraindicated. Residents at the end of life may be excluded from routine weights. The DON or	F 726	1. The facility will ensure there are sufficient nursing staff with the appropriate competencies and skills sets regarding weight loss, accurately weighing and monitoring resident’s weights. This will be accomplished by establishing a consistent method of weighing residents, inservices and competency completion by staff and following weight loss policy established by the facility. All residents in facility were weighed on 6/9/21 to establish a baseline weight and documented in electronic medical record. 2.All residents have the potential to be affected by the alleged deficient practice. All residents in facility were weighed on 6/9/21 to establish a baseline weight and documented in electronic medical record. 3.The Director of Nursing will oversee weight process beginning 6/25/21. Resident weights will be obtained as ordered by clinical staff and given to Director of Nursing or Assistant Director of Nursing to input. Weights will be put in electronic health record by Director of Nursing or Assistant Director of Nursing only. Director of Nursing or Assistant Director of Nursing will monitor weights	

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designee, the Dietary Manager, and the RD will review the weights for the current month and compare the current weight to the 30 and 180 day weights to determine significant weight loss."

An interview by phone with Resident #1's Resident Representative (RR), on 6/7/2021 at 3:10 PM, revealed her concerns of her father's care in the facility. She stated Resident #1 was admitted to the hospital from the facility and she was alarmed when she saw how thin her Dad appeared. She stated that the Resident's weight on admission to the hospital was 128 pounds, and his normal weight was between 170 - 180 pounds. She stated he had tested positive for COVID-19 upon admission to the hospital. She notified the facility and told them, "My father has been neglected by your facility." She stated she informed the DON (Director of Nursing) that her father had a massive weight loss and she wanted the facility to investigate and determine what happened to him and why had no one noticed his decline. She stated that before COVID-19, the Resident's wife and other family members would go to see him daily. She stated they would assist him with meals and other care. Once COVID-19 started, the family could no longer go into the facility to check on him but they could window visit and FaceTime, but they could not get close to him or see how his weight was decreasing. The family was relying on the staff to care for him.She confirmed he was in the hospital from 7/23/2020 - 7/28/2020 and when he was discharged, he had to return to the same facility due to his positive COVID-19 status.He passed away on November 10, 2020.

Interview with the Director of Nursing (DON) on 6/8/2021 at 10:25 AM, the DON stated Resident

while inputting for any weight loss or changes. The Director of Nursing will inservice and complete a competency with clinical staff beginning 6/25/21 on weight loss policy, how to weigh a resident accurately and consistently, and process for obtaining and reporting weights. Maintenance calibrated wheelchair scale on 7/1/21 and will complete calibration weekly x 4 weeks, then monthly x 3 and then every 6 months.

4.Director of Nursing or Assistant Director of Nursing will input all weights into electronic medical record beginning 6/25/21 and will monitor for any weight changes. Director of Nursing or Assistant Director of Nursing will report any weight changes to Interdisciplinary Team in weekly weight meeting for review beginning next scheduled meeting on 6/30/21. Residents with weight loss will be reported to Registered Dietician for review and recommendations. Director of Nursing will report findings to the Quality Assurance and Performance Improvement Committee monthly beginning 6/25/21 and will continue to be monitored monthly indefinitely when there is any resident weight loss.

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#1 was a Resident in the facility He stated his family would visit daily, but when the facility was placed on lockdown due to COVID-19, the family visits were stopped, and Resident #1 began declining. The family did window visits and FaceTtime with the Resident, but that was not the same. He stated he was not at the facility when the incident occurred or when the daughter initially called and spoke to previous administration concerning her father's lack of care and alleged neglect. He stated the RR informed the previous administration of the weight the hospital obtained on her father (Resident #1) which indicated there was a massive weight difference (approximately 50 pounds). He stated when he found out about it, an investigation was started. During the investigation, he determined Licensed Practical Nurse (LPN) #1 was not weighing Resident #1 accurately.He stated LPN #1 was not subtracting the wheelchair weight from the scale weight and Certified Nursing Assistant (CNA) #1 once documented a weight she was told from another staff member. He stated he interviewed all the staff that had worked with Resident #1 and each employee denied they had not weighed the resident and just documented a weight close to the previous weight. Stated he determined one employee admitted he was weighing incorrectly, and therefore an inaccurate weight was obtained. New baseline weights were obtained on each resident and none of the other residents had a significant weight difference.The DON stated some had a smaller difference, but it was hard to determine if it was due to inaccurate weighing or from being on lockdown from COVID-19 and the residents feeling more isolated or a combination of both.

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Interview on 6/9/2020 at 10:00 AM, with the Registered Dietician, when asked about the 54.8 pound weight loss in less than a month for Resident #1 (from 174.8 pounds on 7/16/2020 to a weight of 128 pounds on 7/23/2020-date of hospital admission to weight of 120 pounds on the date RD evaluated on 8/10/2020), and a 46.8 pound decrease in one week (from 174.8 pounds on 7/16/2020 until 7/23/2020's weight of 128 pounds at hospital) the RD stated she would not think that was possible. Stated it could be that the scales were not calibrated accurately.

A phone interview with Certified Nursing Assistant (CNA) #1 on 6/9/2020 at 11:20 AM, revealed she had worked with Resident #1 at this facility and at the previous facility she had worked in, so she knew him well. She stated Resident #1 had a good appetite and would usually "clean his plate and eats snacks too" and did not require much assistance, but as he got weaker, he required the staff to feed him. She stated there were times she weighed Resident #1 and did not remove the footrests or did not subtract the chair weight from the total weight. Stated she did not realize that the footrests and chair itself could make such a big difference. She stated she was in-serviced on weighing residents before this incident and was in-serviced again after incident. She stated she had also documented a weight another staff member had obtained, so that weight may have been inaccurate as well.

Attempts were made to contact LPN #1 on6/8/21 at 5:10 PM, 6/9/21 at 1:15 PM. and 6/11/21 at 9:20 AM.
LPN#1 did not return the call to the State Agency. The facility staff also tried to reach out to him, but no return call.

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Review of facility's weight log revealed Resident #1 with a weight of 174.8 pounds in the facility on 7/16/2020. Review of hospital record revealed one week later, on 7/23/2020, the resident's hospital admission weight was 128 pounds. Hospital records revealed Resident #1 was discharged from the hospital on 7/28/2020 and returned to the facility. Review of the facility's weight log revealed on 7/30/2020, Resident #1's weight was 127.6 pounds.

Record review of the facility's investigation revealed:
- Written statements dated 8/18/2020, by LPN #1 revealed, "I have thought about this weights. I believe I was getting an inaccurate weight because I was not counting the weight of the w/c (wheelchair) accurately. I was not remembering to take the foot pedals off, also it is difficult to set weight because he moves around in the w/c. (Proper Name) (Resident #1) is not compliant with care often trying to climb out of the w/c and leaning during weights." Signed (Proper Name) LPN #1
- Another written statement by LPN #1, undated, revealed, "Sorry. I saw this as I was going out. I have mostly been getting them myself. He was confused several times fighting with the staff so I would just try to catch him and do it when I could. I was trying to get them in the w/c mostly so it was me." Signed (Proper Name) LPN #1
- Written statement by CNA #1, dated 8/7/2020, revealed "On 4/16 I was informed that (Proper Name) Resident #1 weighed 182.6 so that's what I documented. I can't remember who the person was but I do know I just documented what I was told. On 3/12 I weighed (Proper Name)(Resident #1) using the lift and sling in his bed and got

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182.5" Signed (Proper Name) CNA #1 08/07/20 - Disciplinary Form for LPN #1 dated 8/14/2020 listed dates of incident as: "multiple dates from September, 2019 - August 2020.Comments of Department Head, (describing the occurrence(s), indicating the timing between occurrences, and summarizing the action taken or recommended and its justification) stated, "Obtaining and documenting correct weights and processes not being followed. This nurse was obtaining weights himself and states that he forgot to subtract the wheelchair weights with leg extensions from the total weight obtained to acquire the correct baseline weight." Signed by employee (Proper Name) LPN #1 and supervisor (Proper Name) DON.

An interview with Administrator on 6/9/2021 at 2:30 PM, confirmed the facility failed to have a consistent method of weighing a resident.

Interview with the Director of Nursing (DON) on 6/9/2021 at 2:32 PM, the DON confirmed the facility failed to have a consistent method of weighing residents accurately and did not adequately weigh Resident #1 to reveal that he could have possibly had a weight loss.

Record review of the Admission Record revealed Resident #1 was admitted to the facility on 4/4/2019 with diagnoses which included Dementia, Chronic Obstructive Pulmonary Disease, Hypertension, Anxiety Disorder, Vitamin Deficiency, Anemia, Anorexia, Dysphagia Following Unspecified Cerebrovascular Disease; Transient Cerebral Ischemic Attack.

Record review of Minimum Data Set (MDS), Section C - Cognitive Patterns, dated 10/26/2020

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F 726	Continued From page 10 revealed Resident#1 had a Brief Interview for Mental Status (BIMS) score of "0" indicating severe cognitive deficits. Record review of an In-service dated 2/10/20 titled "Weight Monitoring", revealed LPN #1 and CNA #1's signatures were listed on the sign in sheet as attending the inservice.	F 726		