

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255145		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/10/2026	
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SOUTH LOCUST STREET , MCCOMB, Mississippi, 39648			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted five (5) Complaint Investigations (CI MS #3182237, CI MS #3188737, CI MS #3110707, CI MS #3194977, and CI MS #3074770) at the facility from 9/08/26 through 9/10/26. CI MS #3194977 was investigated for labs, laundry and food concerns with no citations. CI MS #3074770 was investigated related to a facility reported incident regarding injury of unknown origin with no citations. CI MS# 3110707 was investigated regarding physical environment hot and uncomfortable and cited F925. CI MS# 3182237 was investigated regarding quality of care related to inadequate feeding assistance, activities of daily living, lack of supplies for resident care, staffing and grievances and F689 and F925 was cited. CI MS#3188737 was investigated regarding resident neglect, accident/fall and quality of care and F689 was cited. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F584, F677 and F800. The facility held a license for 145 beds with a census of 109 residents.			F0000			
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident			F0584			

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255145		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/10/2026	
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SOUTH LOCUST STREET , MCCOMB, Mississippi, 39648			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F0584 SS = D	Continued from page 1 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were provided with a clean, comfortable and homelike environment for four (4) of ten (10) sampled residents. Resident #4, Resident #5, Resident #7 and Resident #10. Findings included: Resident #4 During an interview with the Resident Representative (RR) on 9/08/26 at 5:40 PM, the RR said she had notified the facility staff of problems with Resident #4's wheelchair brakes not holding and other issues on or around 8/08/26 and nothing had been done and Resident #4 was still using the wheelchair without repair. During an observation on 9/08/26 at 6:00 PM, revealed Resident #4 transferred himself from his bed to his wheelchair after engaging wheelchair	F0584					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255145		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/10/2026	
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SOUTH LOCUST STREET , MCCOMB, Mississippi, 39648			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F0584 SS = D	Continued from page 2 locks and his wheelchair moved backwards during the transfer as he put weight on the wheelchair for support. On 9/10/26 at 2:40 PM, observation with the Administrator and Regional Director of Operations (RDO) confirmed the top of the resident's over-the-bed table leaned downward and said it needed pilers to fix and the Administrator said it was not good to put food trays or equipment. On 9/10/26 at 2:50 PM, during observation and interview with the Administrator, RDO and Therapy Director, the Therapy Director revealed he had been made aware of poor condition of the wheelchair of Resident #4 and that the pressure management cushion in the wheelchair had been replaced with a non-fitting cushion that offered little to no pressure management. The right arm rest had two large and several small holes in it and was insecurely attached and the material that covered the left arm rest was cracked on the sides and down the middle and the left wheelchair break did not prevent the wheelchair from moving when locked. The Physical Therapist stated that he had ordered parts for Resident #4's wheelchair four weeks prior and was awaiting delivery. Resident #4 was lying on his bed, and his call light was under the head of his bed on the floor. The RDO pulled the call light out from under the bed and secured it within reach of Resident #4. On 9/10/26 at 4:00 PM, observation and interview with the Physical Therapist revealed he had replaced the left arm rest and the right arm rest, tightened the locks, and replaced the pressure management cushion in the wheelchair with one that fits the wheelchair of Resident #4. Resident #5 During an observation and interview with Resident #5 and the RR on 9/08/26 at 1:00 PM, revealed the RR said she had submitted a grievance because the air conditioning unit in the room of Resident #5 was not cooling on 8/04/26. The RR said that nursing staff told her that the resident was not assisted out of bed into her wheelchair because the required mechanical lift sling was not available. Record review of the Monthly Grievance Log for August 2026 confirmed the report that Resident #5's RR reported "air not working in rm (room)" on 8/04/26. During an observation and interview on 9/10/26 at 2:05 PM, while in the room of Resident #5, the	F0584					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255145		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/10/2026	
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SOUTH LOCUST STREET , MCCOMB, Mississippi, 39648			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0584 SS = D	Continued from page 3 Administrator and RDO acknowledged that there was a nine by three (9X3) centimeter irregularly shaped hole in the wall above the baseboard next to the door and quarter sized dark gray stains on the floor mat on the right side of Resident #5's bed. The RDO indicated that if housekeeping staff were not able to clean the floor mats, maintenance could take them outside and wash them. On 9/09/26 at 1:22 PM, interview with contract Housekeeping Training Center Account Manager (TCAM) and facility contract Account Manager revealed both reported they had not been made aware of lack of clean, dry mechanical lift slings. They said daily resident room cleaning procedures included a five (5) step procedure that included sweeping and mopping the room floor. On 9/10/26 at 6:30 PM interview with the (interim) Director of Nurses (DON) revealed that she had not been notified that there was a problem with getting residents out of bed as desired due to lack of mechanical lift slings. Resident #7 During an observation and interview with the RR on 9/08/26 at 2:00 PM, revealed she had visited on 9/05/26 and Resident #7's room was "hot." She stated that there were two wet, white blankets under the unplugged packaged terminal air conditioner (PTAC) unit under the window of the resident's room. She said staff had plugged the unit into the electrical outlet, and it began to cool the room but 20 minutes later began to "pour water". The RR stated that she returned on 9/07/26 and the unit was still not operating correctly, and she filed an official grievance and the unit was replaced. Observation revealed both filters of the PTAC were covered by 1/8 inch thick (approximately the width of three stacked pennies) with dust. During an interview on 9/08/26 at 2:30 PM, the Maintenance Supervisor revealed that he had replaced the PTAC unit in the room of Resident #7 on 9/07/26 or 9/08/26. He confirmed that the PTAC was draining water onto the floor during operation. He stated that the air filters were supposed to be cleaned every six months and was not sure when the filter of the PTAC in the room of Resident #7 had been cleaned. The Maintenance Supervisor confirmed that he had received a report that the PTAC in the room of Resident #5 and Resident #10 was not cooling and repaired the PTAC unit but was unable to recall date but confirmed that the initial report that the PTAC was not cooling the room			F0584			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255145		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/10/2026	
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SOUTH LOCUST STREET , MCCOMB, Mississippi, 39648			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F0584 SS = D	Continued from page 4 occurred on a weekend and the unit was not replaced until the following Monday or Tuesday. Resident #10 During an observation and interview with the Administrator, RDO and Resident #10 on 9/10/26 at 2:05 PM. Observation revealed Resident #10, a visually impaired, dependent resident said she wanted to lay down on her bed and requested assistance, she said and demonstrated that she could not locate her call light which was out of her reach. The RDO placed the call light within reach of the resident and told her where it was.	F0584					
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff interviews and record review, the facility failed to ensure Activities of Daily Living (ADLs) were provided for four (4) of (10) sampled residents. Resident #4, Resident #5, Resident #6, and Resident #8. Findings included: Resident #4 On 9/09/26 at 2:05 PM observation and interview with Certified Nursing Assistant (CNA) #4 and Resident #4 revealed the resident had ten long rough fingernails with grey, tan and brown substance under each nail. CNA #4 stated that she was taking the resident to provide fingernail care because his were too long, dirty and rough. Resident #5 During an observation and interview with Resident #5 and the RR on 9/08/26 at 1:00 PM, revealed the RR said that nursing staff told her that the resident was not assisted out of bed into her wheelchair because required mechanical lift sling was not available. During an interview on 9/08/26 at 4:56 PM, interview with Licensed Practical Nurse (LPN) #4 revealed she did not know why Resident #5 had not	F0677					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255145		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/10/2026	
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SOUTH LOCUST STREET , MCCOMB, Mississippi, 39648			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0677 SS = D	Continued from page 5 been assisted to transfer out of bed into her wheelchair on 9/08/26 and that she was not aware that the CNA had not been able to locate the required mechanical lift sling. During an interview on 9/08/26 at 5:45 PM, CNA #7 confirmed that Resident #5 was not assisted with chair/bed to chair transfer because the resident required a mechanical lift for transfer and there was not a sling her size available. She said she had reported this to the resident's nurse. Resident #6 On 9/08/26 at 1:45 PM, observation and interview with Resident #6 in her room revealed a foul, malodorous smell of feces and there was an eight and one half inch by eleven inch (8 ½ X 11), approximately the size of a piece of copy paper, layer of a light brown/tan colored substance of greasy consistency under the middle of the bed of Resident #6. Resident #6 confirmed that she was aware of the odor and said, "That's probably my bowel movement (BM). She said she was embarrassed that her "waste" had puddled under the bed. She said she had not been checked for incontinence or received incontinence cares since before 7:00 AM. She stated that she had told CNAs that she had an incontinent episode and needed assistance but was unable to recall the time she first requested assistance but said she had requested assistance a second time for toilet hygiene at 1:20 PM. On 9/08/26 at 3:40 PM, during an interview LPN #4 confirmed that she was assigned to the care of Resident #6 on dayshift (7:00AM-7:00PM) 9/08/26 and was familiar with the resident and her care. She stated, "someone told me that she (Resident #6) said she wasn't changed". She confirmed that the nurses supervised resident care and that she expected CNAs to make rounds every two (2) hours and assess and provide care for incontinent residents as needed. On 9/08/26 at 3:45 PM an interview with CNA #3 revealed she was assigned to the care of Resident #6 from 7:00 AM through 7:00 PM (dayshift) on 9/08/26 and was aware that Resident #6 was always incontinent of bowel and bladder and dependent for toilet hygiene. She reported that she had provided incontinence care/toilet hygiene assistance for Resident #6 once on 9/08/26 at some time after 2:00 PM and confirmed that the resident had incidence of bowel and bladder incontinence.			F0677			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255145		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/10/2026	
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SOUTH LOCUST STREET , MCCOMB, Mississippi, 39648			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0677 SS = D	Continued from page 6 On 9/08/26 at 3:55 PM, interview with CNA # 2 revealed that Resident #6 asked to for incontinence care "when I brought her lunch around 12:00 (PM)...and I told her 'yeah'. I had to go do the smoke break and took smokers out at about 1:45 PM and I went to her around 2:00 something." CNA #2 she was feeding residents, but she had not notified the resident's nurse that the resident had requested incontinence care or requested assistance or inquired if there were other staff available to assist with incontinence care for Resident #6. She confirmed that the resident waited over two hours during which she was served and ate lunch following a reported incontinent episode. On 9/10/26 at 1:35 PM, observation in the room of Resident #6 with the Administrator and Regional Director of Operations (RDO) revealed they confirmed the presence of an eight and one-half inch by eleven inch (8 ½ X 11), approximately the size of a piece of copy paper, layer of a dry, light brown/tan colored substance under the middle of the bed of Resident #6 which wiped off with water and a paper napkin. The Administrator said the substance looked "like dried chocolate milk". Record review of the "Admission Record" for Resident #6 revealed the facility admitted her on 12/30/21 with diagnoses that included morbid obesity, and diarrhea. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/13/26 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Further MDS review revealed Resident #6 was dependent for all other activities of daily living (ADLs) was not able to walk and was always incontinent of bowel and bladder. Record review of the KARDEX care instructions for Resident #6 "As of 9/10/26" revealed Resident Care instructions "Toileting hygiene: Dependent X 1 (with one) staff...Toileting "Check resident every two hours and assist with toileting as needed clean peri-area with each incontinence episode. Provide peri care after each incontinence episode..." Resident #8 On 9/08/26 at 1:10 PM, observation of Resident #8 in her room revealed the resident was resting in bed, she had approximately twelve short, curly white hairs on her chin, her hair that appeared disheveled, unkempt and uncombed with frizzy strands that obscured the braids on each side that wrapped			F0677			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255145		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/10/2026	
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SOUTH LOCUST STREET , MCCOMB, Mississippi, 39648			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0677 SS = D	Continued from page 7 around towards the back of her head where her hair was matted and flat. Resident #8 had ten (10) rough fingernails that extended past the ends of her fingers approximately one eighth (1/8) inch, approximately the width of three stacked pennies, passed the ends of her fingers with dark grey/brown/black substance beneath each. Resident #8 was crying and when asked why she said, "I want to get up". Resident #8 was feeding herself lunch with difficulty due to noticeable hand tremors. On 9/09/26 at 5:30 PM interview with CNA #1 revealed was assigned to the care of and provided personal hygiene for Resident #8 on the dayshift of 9/09/26. She described the resident's hair as disheveled, fuzzy and said it was matted in the back and said, "I had to comb it out" and confirmed that she had removed several short, curly white hairs from Resident #8's chin during am care on 9/09/26 and that Resident #8 as she was totally dependent for all ADLs. She confirmed that Resident #8 had been up in her wheelchair with no incontinence care between 9:30 AM and 4:45 PM. On 9/09/26 at 6:00 PM, interview with CNA #10 confirmed that she and CNA #1 provided incontinence care for Resident #8 at approximately 9:30 AM and again at 4:45 PM. On 9/10/26 at 2:00 PM, observation with the Administrator and RDO revealed Resident #8 was seated in her wheelchair outside her room. RDO confirmed that the resident had (10) long, dirty, rough fingernails and he requested LPN #6 provide fingernail care. Record review of the Quarterly MDS with ARD 6/06/26 for Resident #8 revealed the facility was unable to complete the interview and Resident #8 was dependent for all ADLs. On 9/10/26 at 6:30 PM interview with the (Interim) Director of Nurses (DON) revealed that she expected nurses to supervise resident care and ensure care was provided. She confirmed that she expected the CNAs to review and follow care instructions for each resident according to the KARDEX. She said that personal hygiene included removal of unwanted facial hair for female residents and fingernail care as needed. She stated that if fingernail trimming was needed for residents who required licensed nursing staff, she expected the CNAs to notify their primary care nurse. She also said that fingernail checks were supposed to be included in weekly skin sweeps and addressed as needed. She confirmed that each resident with bowel/bladder incontinence receive			F0677			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255145		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/10/2026	
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SOUTH LOCUST STREET , MCCOMB, Mississippi, 39648			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F0677 SS = D	Continued from page 8 assistance with toileting, toilet hygiene and/or incontinence care as needed and in a timely manner and that each resident with bowel/bladder incontinence should be checked every two hours. She stated that she expected nurses to supervise resident care and ensure care was provided. She confirmed that she expected the CNAs to review and follow care instructions for each resident according to the KARDEX. She said that personal hygiene included removal of unwanted facial hair for female residents and fingernail care as needed. If fingernail trimming was needed for residents who required licensed nursing staff, she expected the CNAs to notify their primary care nurse. She also said that fingernail checks were supposed to be included in weekly skin sweeps and addressed as needed. She confirmed that it was important that each resident with bowel/bladder incontinence receive assistance with toileting, toilet hygiene and/or incontinence care as needed and in a timely manner and that each resident with bowel/bladder incontinence should be checked every two hours.	F0677					
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to provide adequate supervision for one (1) of ten (10) sampled residents when floor waxing blocked nursing staff from accessing her room. Resident #2. Findings Include: Record review of the facility policy review of facility policy " Provision of Quality Care" undated revealed "Policy... the facility will ensure that residents receive treatment and care... to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being..."	F0689					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255145		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/10/2026	
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SOUTH LOCUST STREET , MCCOMB, Mississippi, 39648			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0689 SS = D	Continued from page 9 On 9/09/26 at 11:42 AM, during a telephone interview the Resident Representative (RR) of Resident #2 revealed that the facility admitted Resident #2 on 8/26/26 and left on 8/28/26, not to return. The RR explained that on the evening of 8/28/26 at approximately 7:15 PM, Resident #2 used her cellular telephone Face Time feature to contact her. The RR said she was able to see that Resident #2 was on the floor, crying and said she had fallen due to need for assist with toileting and toilet hygiene and no staff came to her room. The RR said she immediately began to telephone the facility without success and had only the telephone number of the Marketer/Admissions Coordinator and contacted him at approximately 7:40 PM to seek assistance for Resident #2. She reported that she arrived at the facility at approximately 7:55 PM and observed two (2) housekeeping department floor technicians who mopped wax over the width of the 100 Hall who told her that she couldn't walk on the floor. Upon entering the room Resident #2 was seated in her wheelchair next to her bathroom door with a wet trail from the side of her bed to the wheelchair wearing a wet incontinence brief. There was a pile of bed linens on the floor with the call light unplugged from the bedside station call light wall receptacle. She said Resident #2 reported that she had pulled herself across the floor and "crawled into" the wheelchair and that her left ankle hurt. The RR said there were no nursing staff on the 100 Hall and at approximately 8:00 PM located Licensed Practical Nurse (LPN) #1 and Certified Nursing Assistant (CNA) #9 on the 200 Hall and reported Resident #2's fall. She said they both told her that they had not been on the 100 Hall due to the floor being waxed. She said that emergency medical technicians (EMTs) arrived and transported Resident #2 to local hospital via ambulance where evaluation and Xray diagnostics revealed bruised, sprained ankle. She said she had not called 911 or emergency services and did not know who had. On 9/09/26 at 3:00 PM, interview with the facility Marketer/Admissions Coordinator revealed that on 8/28/26 he was contacted by the RR for Resident #2 at approximately 7:40 PM seeking assistance for the resident who was unable to get up after falling with no nursing staff responding to call light and no answer of telephone by facility staff. He said he had attempted to contact facility staff by telephone multiple times with no answer. He said that at approximately 8:15 PM, he spoke with the facility Administrator and a corporate nurse consultant who instructed him to call emergency services to have the resident transported to local hospital emergency department (ED) for evaluation and treatment as			F0689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255145		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/10/2026	
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SOUTH LOCUST STREET , MCCOMB, Mississippi, 39648			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0689 SS = D	Continued from page 10 needed, which he did at approximately 8:20 PM. On 9/10/26 at 1:30 PM, interview with the Administrator revealed she had investigated the unwitnessed fall of Resident #2 on the evening of 8/28/26 but not a root cause analysis. She said she concluded the fall was caused due to the resident's attempt to walk unsupervised and unassisted by staff. On 9/10/26 at 7:26 PM, in an interview CNA #9 revealed she was on duty on the 100 Hall 7:00 PM through 7:00 AM shift (Evening Shift) on 8/28/26 and when she arrived at the facility at 7:00 PM, "They was doing the floors and would not allow us on A (100 Hall)" until a female family member came down the hall at approximately 8:10 PM which was "after I took smokers out at 7:30 (PM)". She said that when she arrived at the facility the Floor Techs were mopping wax onto the entire hallway on the 100 Hall. CNA #9 said, "We hadn't been down there. We were told not to go down the hall." She said she and LPN #1 told the Floor Technicians they were supposed to wait until nursing staff completed 7:00 PM rounds and do one side of the hall at a time, so staff and residents had access to the hallway and resident rooms. She reported Floor Technicians were doing the whole floor at the same time, "So, we were out of luck. He (Floor Technician) stated "We are just doing what the Administrator said, take it up with her." CNA #9 said, "That lady would probably not have been on the floor except for the floor waxing". CNA #9 reported that there were three (3) call lights engaged on the 100 Hall at approximately 8:00 PM when she and Licensed Practical Nurse (LPN) #1 arrived, 117 P was a male resident who wanted a urinal, and 115 P was a male resident who requested pain medicine but is no longer here and 114 P, which was Resident #2's room were engaged and said, "We couldn't go to them." CNA #9 reported when she arrived in her room, Resident #2 was seated in wheelchair and there was a pile of linen and bedding on the floor. She confirmed Resident #2 wore disposable incontinent briefs, was always incontinent and her brief was wet and the resident "looked like she was in distress". When asked why she had not responded to call lights on the 100 Hall between 7:00 PM and 8:10 PM, she said, "Technically we were supposed to go. "(Name of) LPN #1 was giving medicine, and I was outside I don't know why it wasn't answered." On 9/10/26 at 8:30 PM, interview with the Administrator and the Regional Director of Operations (RDO) revealed that she did not consider the waxing of the 100 Hall at 7:00 PM on 8/28/26 to			F0689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255145		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/10/2026	
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SOUTH LOCUST STREET , MCCOMB, Mississippi, 39648			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0689 SS = D	Continued from page 11 be a factor in the unwitnessed fall of Resident #2 because, "They weren't waxing in the residents' rooms". She stated that she was unaware that Floor Techs had applied wax to the entire hallway instead of one side at a time to allow for care of residents and staff and resident access to 100 Hall rooms until after the incident. She confirmed that she had a conference call with the Corporate Nurse Consultant and the facility Marketer/Admissions Coordinator at approximately 8:15 PM on 8/28/26 and the Consultant instructed Emergency Medical Services (EMS) be summoned to transfer Resident #2 to local hospital ED for assessment and treatment as needed. She confirmed that the ED reported that the resident had sustained bruising and sprained left ankle. On 9/10/26 at 8:53 PM, during a telephone interview, LPN #1 confirmed that she was on duty on the evening shift assigned to the 100 and 200 Hall (A/B Unit) on 8/28/26 when she arrived two (2) Floor Techs were mopping wax all over the entire hallway of the 100 Hall. She stated the floor techs told her to stay off the hall. She said she told them that they were not supposed to begin waxing until nursing staff completed 7:00 PM rounds and were to only apply wax to one side of the hallway to allow access to residents and nursing staff. They replied they were only doing what the Administrator instructed. She stated that neither she nor the CNAs made rounds, answered call lights, monitored, supervised or provided care for residents in the rooms on 100 Hall until approximately 8:10 PM, when Resident #2's RR located her on the 200 Hall and informed her that Resident #2 had fallen. She said she gathered equipment, assessed a Resident who was seated in wheelchair in her room wearing a wet incontinence brief and a gown and noted a new bruise on the resident's left lower leg. She confirmed that there were call light indicators lit above three (3) resident doors at 8:10 PM and she did not know how long they had been on. She stated that the last time nursing staff observed Resident #2 prior to the incident on 8/28/26 was at approximately 6:40 PM on the prior shift and confirmed that according to resident and family report the resident had fallen prior to 7:30 PM. She said she did not know how long the resident was on the floor or how long the call light had been engaged. She confirmed that there were call light indicators lit above (3) resident doors when she and other nursing staff responded to the family request for assistance at approximately 8:10 PM. She confirmed Resident #2 had been upset and reported pain in her left leg. She said it was her opinion that Resident #2 may not have fallen if the nursing staff			F0689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255145		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/10/2026	
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SOUTH LOCUST STREET , MCCOMB, Mississippi, 39648			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0689 SS = D	Continued from page 12 would have been able to make rounds at 7:00 PM, answer call lights and walk on the floor of the 100 Hall because nursing staff would have provided monitoring and supervision. Record review of the "Order Summary" for Resident #2 revealed an order dated 8/28/26, "May send to ER for eval and treatment for any significant changes post fall. Obtain X-ray of left lower leg and left foot r/t fall." Record review of the "Admission Record" for Resident #2 revealed the facility admitted her on 8/26/26 and she had diagnoses of postprocedural hematoma of a circulatory system organ following a cardiac catheterization, weakness, unsteadiness on feet, dysphagia, aphasia, cerebral infarction (stroke), presence of aortocoronary bypass graft, chronic obstructive pulmonary disease (COPD), and diabetes. Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/28/26 revealed Resident #2 was dependent for toileting and perineal hygiene, dressing, to come to a standing position from sitting, for chair/bed-to chair transfers (transfer to and from a bed to a chair or wheelchair.), toilet transfer to get on/off toilet. Resident #2 required substantial/maximal assistance for lying to sitting on side of bed and required partial/moderate assistance to walk ten (10) feet and was always incontinent of bowel and bladder. Record review of the "Progress Notes" dated 8/26/26 documented as an "Admission Note" revealed that the resident was dependent on staff for all transfers, considered chair bound, and incontinent of bowel and bladder. Record review of the Post Fall Evaluation dated 8/28/2026 at 8:25 PM created by LPN #1 revealed the fall was not witnessed, occurred in the resident room and resulted in an injury to the resident's ankle which resulted in an emergency department visit. There was also a purple discoloration to left medial shin. Record review of the Kardex for Resident #2 revealed: "... Ensure/provide a safe environment: Call light in reach..." Record review of the Documentation Survey Report v2 for Resident #2, which documented care provided by CNAs revealed no interventions or tasks documented for Resident #2 on 8/28/26.			F0689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255145		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/10/2026	
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SOUTH LOCUST STREET , MCCOMB, Mississippi, 39648			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0800 SS = D	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents received the appropriate diet to meet nutritional needs and preferences for one (1) of ten (10) sampled residents. Resident #5. Findings included: On 9/09/26 at 12:30 PM observation and interview with CNA #11 revealed she provided assistance for Resident #5 to eat lunch. The resident's mashed potatoes had not been disturbed, and her strawberry-flavored nutritional supplement beverage had not been opened. CNA #11 said Resident #5 declined mashed potatoes and "didn't like" the supplement and wouldn't drink it. When asked by the State Agency (SA) if the resident may consume the supplement if it had been opened, she opened the carton, poured it into a white Styrofoam cup with a straw and lid, and handed it to Resident #5 who drank 100% of supplement. On 9/10/26 at 6:00 PM, interview with CNA #11 confirmed that on 9/09/26 while assisting Resident #4 with eating lunch she had not offered the resident an alternate of equal or greater nutritional value when she declined potatoes. She confirmed that proper procedure for assisting a resident with eating included opening all containers on the resident's tray and she had not opened or offered Resident #5 the supplement included on her lunch tray on 9/09/26. Record review of the "Admission Record" for Resident #5 revealed the facility admitted the resident on 1/08/18 and Resident #5 had diagnoses of dementia, and hemiplegia and hemiparesis following cerebral infarction (stroke) affecting left dominant side. Record review of the Quarterly Minimum Data Set (MDS) for Resident #5 with Assessment Reference Date (ARD) 6/24/26 revealed the facility assessed			F0800			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255145		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/10/2026	
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SOUTH LOCUST STREET , MCCOMB, Mississippi, 39648			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F0800 SS = D	Continued from page 14 the resident had a Brief Interview for Mental Status (BIMS) score of 4, which indicated severe cognitive impairment. Record review of the KARDEX care instructions for Resident #5 "As of 9/10/26" revealed ". Eating Dependent... ..Cue, reorient and supervise as needed... On 9/10/26 at 6:30 PM interview with the (interim) Director of Nurses (DON) revealed that she expected CNAs to open all containers/cartons on resident meal trays and offer all items to each resident as well as alternative food items if the resident declined food items on their trays and confirmed it was important for residents' nutritional health and skin integrity.	F0800					
F0925 SS = D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews the facility failed to ensure the facility was free from pest for a common area dining room and three (3) of ten (10) sampled residents. Resident #4, Resident #5 and Resident #10. Findings included: Resident #4 On 9/08/26 at 1:10 PM, during an observation revealed Resident #4 and his roommate were eating. There was a housefly flying around both residents as they ate. Resident #5 During an observation and interview with Resident #5 and the Resident Representative (RR) on 9/08/26 at 1:00 PM, the RR assisted Resident #5 with eating while in bed. There was a housefly flying around the resident and a fly swatter on the bedside table. The RR reported the fly swatter belonged to her. She reported that she used it because there were "always flies and gnats in the room". Resident# 10 During an observation and interview with the	F0925					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255145		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/10/2026	
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SOUTH LOCUST STREET , MCCOMB, Mississippi, 39648			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0925 SS = D	Continued from page 15 Administrator, Regional Director of Operations (RDO) and Resident #10 on 9/10/26 at 2:05 PM, in the room of Resident #10 revealed there was a housefly on the straw in a cup on the over-the-bed table of Resident #10. The RDO removed the cup and threw the straw away and acknowledged the house fly. Observation revealed Resident #10, a visually impaired, dependent resident, said she wanted to lay down on her bed and requested assistance. She demonstrated that she could not locate her call light which was out of reach. The RDO acknowledged the call light was not in place and placed the call light within reach of the resident and told her where it was. During an observation on 9/10/26 at 2:10 PM, upon leaving the room of Resident #10 with the Administrator and RDO revealed a gnat flying around the face of an unsampled resident who was swatting at the gnat. On 9/10/26 at 2:15 PM, observation with the Administrator and RDO in the common dining room next to the Unit A/B nurses station revealed double windows on each side of a tan colored fireplace across from the entrance door with eight (8) unsampled residents present and there were seven (7) dead plecia nearctica (commonly called love bugs) and a spider web in the right corner of the window on the right of the fireplace. There were nine dead and one dead housefly, one dead spider and a spider web in the left corner of the window on the right of the fireplace. There was a broken green balloon, a spider web, two dead houseflies, one dead ant and six dead love bugs in the right corner of the window on the left of the fireplace. There were 26 dead love bugs, (1) live love bug, (1) dead moth, and a spider web in the left corner of the window to the left of the fireplace. The Administrator and RDO acknowledged the findings in the common dining room. During an interview on 9/10/26 at 2:30 PM, the Housekeeping District Manager and facility Housekeeping Account Manager revealed the housekeeper assigned to the cleaning of the common dining room was not available for interview and confirmed that the windowsills of both double windows contained signs of pests that had not been cleaned prior to or since lunch.			F0925			