

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(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	
M0000	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. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. CI MS #3194977 was investigated for labs, laundry, environment and food concerns and M970 was cited. 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 with no citations. 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 M610 was cited. CI MS #3188737 was investigated regarding resident neglect, accident/fall and quality of care and M640 was cited.		M0000				
M0610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This LICENSURE 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.		M0610				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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M0610	Continued from page 1 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 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			M0610			

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M0610	Continued from page 2 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. 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.			M0610			

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M0610	Continued from page 3 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 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 eight (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			M0610			

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M0610	Continued from page 4 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 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.		M0610				
M0640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies.		M0640				

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M0640	Continued from page 5 This LICENSURE 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..." 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	M0640					

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M0640	Continued from page 6 #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 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			M0640			

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M0640	Continued from page 7 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 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	M0640					

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M0640	Continued from page 8 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 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.			M0640			

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M0640	Continued from page 9 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.		M0640				
M0970	45.33.4 Control of insects, rodents, etc. Control of insects, rodents, etc. The facility shall be kept free of ants, flies, roaches, rodents, and other insects and vermin. Proper methods for their eradication and control shall be utilized. This LICENSURE 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		M0970				

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(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	
M0970	Continued from page 10 During an observation and interview with the 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.	M0970					