STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255145	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Health and Rehabilitation	501 South Locust Street McComb, MS 39648

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on observation, interview, record review, and facility policy review, the facility failed to provide supervision and implement effective elopement prevention strategies for one (1) of four (4) sampled residents (Resident #1), who had a known cognitive impairment and elopement risk, resulting in an incident of elopement.The facility's failure to ensure supervision and implement interventions-including failure to detect the resident's absence promptly, and failure to secure exit doors-resulted in Resident #1 exiting the facility through the front entrance without staff knowledge and being unsupervised in the community for approximately one (1) hour and twenty-nine (29) minutes. The resident was found approximately two (2) miles away at a local business after receiving a ride from an unknown individual. This failure placed Resident #1 in a situation that was likely to cause serious injury, serious harm, serious impairment, or death, given the resident's severe cognitive impairment, multiple medical diagnoses, and the environmental risks encountered during elopement (e.g., traffic, extreme heat, lack of supervision).The facility's failure to ensure supervision and implement interventions for Resident #1, who was an elopement risk, put this resident and all other residents at risk for wandering and elopement, at risk for serious injury, serious harm, serious impairment, or death.This situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 08/07/2025, when Resident #1 exited the facility unsupervised and without authorization. The State Agency (SA) notified the Administrator of the Immediate Jeopardy on 08/11/2025 at 4:15 PM and provided an IJ Template.The State Agency (SA) validated the Corrective Action Plan on 8/13/25 and determined that the IJ was removed on 8/9/25, prior to exit. Findings include:Record review of the facility policy titled, Missing Patient/Resident with Revision Date 8/01/2020 revealed, OVERVIEW: Staff will investigate cases of missing patient/resident and possible elopement. An elopement occurs when a patient/resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so, placing the patient/resident at risk for harm or injury. Record review of the facility policy Accident and incident Investigation with Effective Date 11/30/2014 revealed, Policy: Certain Accidents and Incidents.will be investigated to determine root cause and provide for opportunity to decrease future occurrences of the event. Record review of the facility policy Elopement/Wandering Risk Guideline with Revision Date 8/01/2020 revealed, Overview: To evaluate and identify patient/residents that are at risk for elopement and develop individualized interventions.Record review of the Incident Report dated 8/07/25 revealed documentation of the elopement and return without injury of Resident #1 on 8/07/25.Record review of the facility Verification of Investigation dated 8/07/25 revealed on 8/7/25 at 11:10 AM the nurse discovered Resident #1 was unable to be located. Facility staff called a Code Yellow and searched for the resident. The local police department and the Resident Representative (RR) were notified. At 11:53 AM the local police department notified the facility the resident had been found. At 12:05 PM, the Resident returned to the facility and was assessed by the Nurse Practitioner with no injury noted. On 8/11/25 at 10:10 AM, during a record review of the Facility Investigation and Incident Report both dated 8/7/25 and an interview with the Administrator and the Director of Nursing (DON), revealed the DON reported that the elopement of Resident #1 was discovered when Licensed Practical Nurse (LPN) #1 realized she no longer saw the resident sitting in the lobby where he had been last observed at or around 10:30 AM. The DON reported that she was on D Hall at approximately 10:45 AM when LPN #1 reported to her that she was unable to locate Resident #1. The DON immediately notified the Administrator at approximately 11:10 AM. At approximately 11:15 AM the DON notified the Administrator and called a CODE YELLOW using the overhead public announcement (PA) system. They reported that the resident was last seen seated in a chair in the lobby facing the reception desk and main entrance at approximately 10:30 AM in the lobby across from the front door. The DON and Administrator both said that in separate interviews with the resident upon return to the facility he had told them that he left the facility through the front door when visitors were coming in/going out. The Administrator and DON both confirmed that the resident was last observed in the facility at approximately 10:30 AM and was out of the facility unattended by staff for approximately one hour and twenty-nine minutes when he was observed at a local laundromat two (2) miles from the facility with no obvious injury. They explained that the system of how staff was made aware of a missing resident included word of mouth and Code Yellow announced over the overhead PA system. They explained that they call the alert anytime a resident couldn't be located and hadn't signed out using the alert, Code Yellow which was called at 11:20 AM on 8/07/25. The Administrator confirmed the report by the DON that the Administrator had been notified of a missing resident at 11:15 AM