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	10/20/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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F 0600 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 ensure that residents were free from abuse, neglect, and intimidation when it admitted and retained a resident with known aggressive and violent behaviors (Resident #1) without implementing adequate supervision, behavioral interventions, or protective measures for other residents. The facility's failure to provide necessary psychiatric intervention or to relocate vulnerable roommates placed residents at risk for serious injury, harm, impairment, or death, resulting in an immediate jeopardy to resident health and safety. This deficient practice directly affected three (3) of four (4) sampled residents. Resident #2, Resident #3, and Resident #4.The facility failed to ensure that residents were free from abuse and neglect when it did not provide adequate supervision or implement effective interventions to prevent the ongoing aggressive and combative behaviors of Resident #1. This failure resulted in an unsafe environment and placed Resident #1 and other residents at risk for serious injury, harm, impairment, or death. During the investigation of the complaint, the SA identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 9/10/25 and existed at:42 CFR S483.12(a)(1) Free from Abuse and Neglect (F600) - Scope/Severity (S/S) of JThe SA notified the facility's Administrator of the IJ and SQC on 10/17/2025 at 12:51 PM and provided the Administrator with the IJ templates.The facility submitted an acceptable removal plan on 10/17/25 in which the facility alleged all corrective actions were completed on 10/17/25 and the IJ was removed on 10/18/25, therefore, the scope and severity of 42 CFR S483.12(a)(1)Free from Abuse and Neglect (F600), was lowered to a scope and severity of D while the facility develops a plan of correction to monitor the effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements. Cross Reference: F689Findings include:A record review of the Abuse, Neglect and Exploitation Policy with implementation date of 6/1/25 revealed, Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse. IV. Identification of Abuse. Possible indicators of abuse include, but are not limited to: 1. Resident or staff report of abuse. 5. Verbal Abuse. 7. Psychological abuse of a resident observed. 10. Sudden or unexplained changes in behaviors and/or activities, such as fear of a person.At 11:03 AM, on 10/16/25, in an interview with Resident #2, who shares an adjoining room with Resident #1, he revealed that there were multiple times when Resident #1 would come through their adjoining bathroom door and yell at him while he was in bed at night, cussing and making threats that he was going to harm him. He said he could not sleep while that man was next door. He stated that he simply did not feel safe while Resident #1 was staying next door. He indicated that all staff were aware of what was happening and were attempting to calm Resident #1 and prevent him from entering his room. At 11:46 AM, on 10/16/25, in an interview with Resident #1's roommate, who is Resident #4 explained that Resident #1 cursed at him, called him names, and made threats, stating he was going to kill him. However, these incidents did not occur frequently. When he pressed the call light, the staff would come and try to calm Resident #1 down. The most recent time was when they tried to calm Resident #1, but he barricaded them in the room, preventing anyone from coming in.At 11:55 AM, in an interview with Resident #3, who is in a room across the hall from Resident #1, revealed that she was afraid of Resident #1 and would not come out of her room when he was yelling in the halls.At 12:10 PM, on 10/16/25, in an interview with Licensed Practical Nurse (LPN) #1, she revealed that on Sunday, 10/12/25, during the 1:30 PM smoke break, she observed Resident #2 crying and saying, That boy down there, out of frustration and because he was tired of him being there. During an interview with the Registered Nurse (RN) Unit Manager at 12:38 PM, on 10/16/25, the resident explained Resident #1's initial behaviors, which started when he first admitted , when his medication nurse reported to her that the resident was refusing to take medications, taking medications off her cart, and making it difficult for her to pass meds. When she went to investigate, she found him standing in the doorway of his room. She attempted to give him his medicine, but he refused and walked down the hall, threatening to kill everyone. At that point, she still did not identify him as a danger to himself or the residents. A few days later, she reported that he chased her back to the nurse's station and cornered her. She indicates that it was during that incident that she contacted her Assistant Director of Nursing (ADON), who was in her office at the time, via text to inform her and the Director of Nursing (DON) about what had happened, stating that he needed to be sent out due to uncontrollable aggressive behaviors. She went on to say that during this time, Resident #2 was very afraid of Resident #1 and wouldn't go to the bathroom because it adjoined Resident #1's bathroom. To ease him, she and the

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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)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents were protected from a resident who was admitted with known aggressive behaviors and failed to provide adequate supervision and interventions for that resident. The facility admitted and continued to retain Resident #1 without ensuring appropriate psychiatric care, enhanced supervision, or reassignment of vulnerable roommates. This systemic failure directly affected three (3) of four (4) sampled residents. Resident #2, Resident #3, and Resident #4. The facility's failure to provide adequate supervision to prevent the exhibited aggressive and combative behaviors of Resident #1 placed this resident, and other residents at risk, in a situation that was likely to cause serious injury, harm, impairment, or death. The facility's failure to identify the need for adequate supervision and ensure a secure environment contributed to Resident #1's exhibited aggressive and combative behaviors and placed all residents who were admitted with at risk. This failure resulted in Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 09/10/25.The IJ and SQC existed at: CFR 483.25(d)(1)(2) Free of Accidents Hazard/Supervision/Devices (F689) Scope and Severity (S/S) - JThe SA notified the facility's Administrator of the IJ and SQC on 10/17/2025 at 12:51 PM and provided the Administrator with the IJ templates.The facility submitted an acceptable removal plan on 10/17/25 in which the facility alleged all corrective actions were completed on 10/17/25 and the IJ was removed on 10/18/25, therefore, the scope and severity of 42 CFR S483.12(a)(1)Free from Abuse and Neglect (F600), was lowered to a scope and severity of D while the facility develops a plan of correction to monitor the effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: On 10/16/25 at 12:38 PM, during an interview the Registered Nurse (RN) Unit Manager stated that Resident #1 was admitted on [DATE] and had such behaviors as refusing medications and threatening to harm staff. This escalated to him chasing her toward the nurse's station and cornering her against the wall. As a result, she contacted her Assistant Director of Nursing (ADON) and other administrative staff via group text. She requested that the resident be sent out because he could not be redirected. However, there were no beds available at the two behavioral centers they called, so Resident #1 had to stay at the facility until one became available. She revealed that the adjoining roommate, Resident #2, was fearful and not relocated. She indicates that while other nurses monitored Resident #2 during the day shift, she is unaware whether anyone watched the resident at night and acknowledges that it was not fair for residents to remain in fear.On 10/16/25 at 1:29 PM, during an interview the ADON stated that Resident #1 refused medications, at one point trapped his roommate by preventing staff entry, barricaded himself in another resident's room, slammed a fire extinguisher, and required police intervention. She stated his admission records indicated violent behavior, but at times he was calm.On 10/16/25 at 1:57 PM, during an interview the Director of Nursing (DON) confirmed the resident was discharged on 10/12/25. She explained that the admission records reflected paranoia and psychosis, but she was unaware of the extent of violent behaviors, acknowledged that the roommate or the adjoining resident was not relocated, and stated she would have moved them had she known the risk.On 10/16/25 at 12:10 PM, Licensed Practical Nurse (LPN) #1 reported that on 10/11/25 she observed the resident in the bathroom doorway holding a Bible and clippers saying, I'm going to kill you. She stated that she documented but did not notify supervisory nurses, and that the following day the resident again barricaded himself in the room, requiring police to be notified. She observed Resident #2, who resided in the adjoining room, crying on the smoking porch due to fear.On 10/16/25 at 3:32 PM, during an interview, LPN #2 reported Resident #1 paced at night, entered other residents' rooms, and yelled and threatened when redirected, and that Resident #2 was impacted as he avoided his room at times, and stayed in activities during the day, and refused to go to use the adjoining bathroom at night due to fear. LPN#2 stated that no interventions beyond verbal reassurance were implemented and that there was no relocation of the roommate because the resident was not aggressive all the time.On 10/16/25 at 11:02 AM, during an interview Resident #2 explained he had the adjoining room to Resident #1, who repeatedly entered through the shared bathroom, yelled, cursed, and threatened him with harm. He stated that he could not sleep and did not feel safe. He stated that staff were aware and attempted redirection for Resident #1 and that police ultimately intervened.On 10/16/25 at 11:46 AM, in an interview with Resident #4 stated that Resident #1 cursed and threatened to kill him. He stated that he activated the call light and that Resident #1 barricaded the door, preventing staff entry, and that the police removed the