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	06/18/2026

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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, record review, facility policy review, and interview, the facility failed to ensure that a Spanish-speaking resident had access to language assistance services to prevent cultural and language barriers to care and quality of life for one (1) of (1) Spanish-speaking resident reviewed for communication needs. Resident #1. Findings included:Record review of the facility policy titled, Non-Discrimination-Language Assistance Services with Revision Date 10/14/25 revealed, It is the policy of this facility to take reasonable steps to ensure that individuals with Limited English Proficiency (LEP) are not discriminated against and have access to language assistance services and meaningful communication involving their medical conditions, treatment, and other vital documents.Language assistance will be provided in-person or remotely by a qualified interpreter and/or the use of qualified bilingual or multilingual staff.The facility must not.Rely on staff other than qualified interpreters, qualified translators, or qualified bilingual/multilingual staff to communicate with individuals with LEP If the facility provides a qualified interpreter for an individual with LEP through video remote interpreting services, the facility must ensure the modality allows for meaningful access and must provide.Adequate training to users of the technology and other involved persons so that they may quickly and efficiently set up and operate the video remote interpreting services .On 6/17/26 at 12:10 PM, during an interview the Director of Nurses (DON) revealed the facility had a tablet that was portable and video remote interpreting services to facilitate communication with Resident #1, who had been assessed upon admission and since as Spanish speaking. She confirmed that there was not a communication board for use in communication with Resident #1. On 6/17/26 at 12:15 PM, during an interview the Administrator reported that the facility had one non-English speaking resident, Resident #1, and that the facility had obtained a portable tablet and video remote interpreting services to facilitate communication with Resident #1.On 6/17/26 at 1:15 PM, during an interview CNA #1 revealed she did not utilize the facility tablet with translator services provided by the facility and had not received training regarding its use for communication with Resident #1.On 6/17/26 at 1:18 PM, interview with CNA #2 revealed she reported that she used pointing with her finger and hand gestures to communicate with Resident #1 and did not utilize the facility tablet with translator services provided by the facility and had not been provided training regarding its use for communication with Resident #1.On 6/17/26 at 1:21 PM, during an interview, CNA #3 said she pointed (with her finger) to communicate with Resident #1. She reported she did not utilize the facility tablet with translator services provided by the facility and had not received training regarding its use for communication with Resident #1. She stated she wasn't sure but that being able to communicate with Resident #1 in Spanish could positively impact resident care and redirection of the resident as needed. On 6/17/26 at 1:38 PM during telephone interview the Resident Representative (RR) for Resident #1 voiced concern that the resident was portrayed as noncompliant and combative because the facility staff did not use any translator or communication aides to communicate with Resident #1, who spoke Spanish and little to no English. The RR said that they would not call her to translate or try to communicate with the Resident, especially during incidents to try to deescalate episodes of resistance to care or combativeness.On 6/17/26 at 2:28 PM, interview and observation with the Social Services Director (SSD) revealed the facility had (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	procured a tablet and subscribed to a language translation service to provide a method of communication between Resident #1 and health care staff. The tablet was secured on a rolling stand for mobility, and the SSD confirmed it was kept in her office. She confirmed that she locked her office when she left the facility Monday through Friday afternoons and that it was available to nursing staff as needed. She said that she was not aware of any directions or instructions for the use of the video remote interpreting services or the numeric key code to open her office door posted at the nursing station for use of the service. She said she was not aware of any communication board for use for brief interactions or communication with Resident #1. On 6/17/26 at 3:00 PM, interview with the Activity Director revealed that she had not utilized the tablet and video remote interpreting services to facilitate communication with Resident #1 but was aware of its location. She said she had not received any training in using the tablet or the facility's translation service. She said she was not aware of any communication board for use for brief interactions or communication with Resident #1.On 6/17/26 at 3:50 PM, observation and interview with Resident #1 during which the State Agency (SA) was able to speak limited conversational Spanish, coupled with the use of cellular telephone for translation, was able to have a conversation with Resident #1, who was neat, clean, and free from malodorous smells. Her demeanor was pleasant, calm and welcoming. She was able to understand and answer simple questions in Spanish.On 6/17/26 at 4:45 PM, interview with CNA #4 revealed the scheduled CNAs rotated from hall to hall but that she had been assigned to the care of Resident #1 and familiar with her and her care. She stated that she was not aware of or received training regarding a device for translation/communication with Resident #1 until 6/17/26. She confirmed that she had never used the tablet for communication with Resident #1. On 6/18/26 at 12:14 PM, during a telephone interview, NP #1 reported that she visited Resident #1 routinely for assessment and was unaware of the video remote interpreting services and had not received any training related to the use of the service for communication with Resident #1. She confirmed that she observed the incident on 6/04/26 and that the CNA had not utilized the service or any communication or translation aide/device to communicate with the resident.On 6/18/26 at 2:10 PM, observation of Resident #1 with the SSD in the resident's room revealed the SSD utilized a tablet and video remote interpreting services to conduct a Minimum Data Set (MDS) assessment. The SSD began with the resident walking around the room, and the resident was not concentrating on the interview questions. After the SSD asked the translator to ask the resident to sit down, the resident did so and was more involved with the interview and although she was unable to answer some of the questions, she interacted with the SSD and translator much more. The SSD did not ever ask the translator to translate the resident's responses to her questions or what the resident had said when she spoke. SA speaks limited conversational Spanish and was able to understand some of the resident's responses and spontaneous remarks. Resident #1 was not asked by the SSD or translator if she needed or wanted an interpreter to communicate with a doctor or health care staff. When the SSD asked Resident #1 through the translator if she felt lonely or isolated, she confirmed that she did. She said she felt lonely at the facility. The resident was oriented to self and easily answered questions related to her vision, hearing and dental health. On 6/18/26 at 4:10 PM, during interview the DON confirmed that there was no communication board for use with Resident #1 and that while the facility had a device for communication with Resident #1 staff may not have been aware of it or how to use it. She stated that she was not sure if use of the device and communication aides would affect staff interactions with the resident or attempts at redirection during episodes of difficult behavior.On 6/18/26 at 4:30 PM during interview with the Administrator revealed he was not aware that nursing staff and health care providers were not utilizing the facility provided device for communication with Resident #1. He said that the facility would do what they needed to do to meet the needs of Resident #1, and all residents, including training staff in the use of the device and language service for communication with Resident #1.Record review of the Progress Note for Resident #1 revealed a Physician Progress Note dated 6/04/26 signed by Nurse Practitioner (NP) #1 documented observation of an incident in which (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 was seen plundering through and taking the belongings of another resident that were out in the hallway and a CNA (unnamed) attempted to retrieve the belongings during which Resident #1 became combative with the CNA. Record review of the Progress Note for Resident #1 dated 6/16/26 at 9:04 PM revealed Licensed Practical Nurse (LPN) #1 documented Resident throwing things and hitting staff for redirecting her. On 6/19/26 at 1:41 PM, in a post exit interview, LPN#1 returned a telephone call to the SA and during the telephone interview reported that she was not aware of a device at the facility to facilitate communication through language translation for Resident #1 and had not received any training regarding the device. She confirmed that she was on duty on 6/16/26 when Resident #1 displayed combative behavior and struck staff attempting to redirect her. She stated that the staff attempting to redirect Resident #1 did not speak Spanish, did not attempt to use any communication aides or device, and had not contacted family to assist with communication. She stated that she did not know if use of translation service or communication aides would have had any impact on the resident's behavior or the interaction with staff. Record review of the admission Record for Resident #1, revealed the facility admitted the resident on 6/11/25 and the resident had diagnoses of senile degeneration of brain, dementia, Alzheimer's Disease, anxiety, restlessness and agitation.Record review of the Quarterly MDS with an Assessment Reference Date (ARD) of 3/20/26 for Resident #1 revealed a Brief Interview for Mental Status (BIMS) score as 0 which indicated severe cognitive impairment. The facility documented that the resident's preferred language was Spanish and that she needed or wanted an interpreter to communicate with a doctor or health care staff.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review, facility policy review and interviews the facility failed to ensure that staff followed standard and transmission-based precautions to prevent spread of infections, when an Registered Nurse (RN) did not follow Enhanced Barrier Precautions (EBP) during direct care/replacement of the resident's leaking catheter drainage and collection component for one (1) of two (2) sampled residents with indwelling catheters. Resident #6. Findings Included:Record review of the facility policy titled, Standard Precautions Infection Control with Revision Date 11/14/25 revealed the policy stated, All staff are to assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. Therefore, all staff shall adhere to Standard Precautions to prevent the spread of infection to residents, staff and visitors. Standard Precautions refer to the infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status. This includes.selection and use of PPE e.g., gloves, gowns.environmental cleaning and disinfection.Resident-Care Equipment and Instruments/Devices: a. Policies and procedures have been established for containing, transporting, and handling resident-care equipment and instruments/devices that may be contaminated with blood or body fluids. Personnel are trained in the use of these procedures. b. Wear PPE (e.g., gloves, gowns, etc.) when handling resident-care equipment and instruments/ devices that are visibly soiled or may have been in contact with blood or body fluids.Gown During procedures and resident-care activities when contact of clothing/exposed skin with blood/body fluids, secretions, and excretions is anticipated.On 6/18/26 at 2:22 PM, observation and interview with Resident #6 revealed a strong urine smell in the hallway (100 Hall) outside the resident's room which was very strong in his room. There was a posted notice (with pictures as well as printed instructions) that gowns and gloves were required for contact procedures on the door of the room of Resident #6 for EBP. Resident #6 stated that he thought he had acclimated to the odor but said that he was able to see the partially dried urine on the floor coming out from under his bed. Observation revealed the resident had catheter tubing extending from under his bed covers onto the floor and up to a urine collection bag with three (3) inches of the catheter tubing laying on the floor next to the resident's bed in urine that covered an area of four (4) feet by three (3) inches under the resident's bariatric bed and continued to cover an additional area four (4) feet long by one (1) foot wide along the wall under the window to the wall/corner on the right side of the window as viewed from the doorway into the room.On 6/18/26 at 3:30 PM, observation revealed the facility Infection Preventionist (IP)/RN #1 confirmed that there was urine on the floor of Resident #6's room and that his catheter bag was leaking. RN #1 changed the tubing and urine collection bag for Resident #6 without donning a disposable gown, which was required according to EBP. The resident's catheter was not changed.On 6/18/26 at 4:10 PM, during an interview the Director of Nursing (DON) confirmed that no catheter tubing should be on the floor for infection prevention, and she expected nursing staff to wear appropriate personal protective equipment (PPE) for the direct care of residents on EBP.On 6/18/26 at 4:30 PM, during an interview the Administrator revealed he expected nursing staff to wear appropriate PPE for the direct care of residents on EBP and follow current infection prevention standards of practice.On 6/18/26 at 5:00 PM, in an interview the IP confirmed that Resident #6, along with all residents with urinary catheters, was on EBP and that RN #1 had failed to wear a disposable gown for direct care while changing the catheter tubing and urine collection container for Resident #6 at 3:30 PM on 6/18/26. Record review of the admission Record for Resident #6 revealed the facility admitted him on 3/06/26 and he had diagnoses of heart failure, sepsis (unspecified organism acute infection present on admission), retention of urine, stage 3 chronic kidney disease, and stage 3 pressure ulcer of right button (present on admission).Record review of the Significant Change Minimum Data Set (MDS) for Resident #6 with Assessment Reference Date (ARD) 5/21/26 revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was cognitively intact. The facility assessed the resident was dependent for all activities of daily living and had active diagnoses of neurogenic bladder and urinary tract infection (UTI) and had an indwelling catheter.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, record review, facility policy review and interviews, the facility failed to maintain an effective pest control program so that the facility was free of pests for five (5) of seven (7) sampled residents, Resident #1, Resident #2, Resident #3, Resident #4 and Resident #6. Findings included:Record review of the facility policy titled, Safe and Homelike Environment with Revision Date 10/14/25, revealed the policy stated, In accordance with resident's rights, te facility will provide a safe, clean, comfortable and homelike environment.This includes ensuring that the resident can receive care and services safely and that the physical layout.does not pose a safety risk.Sanitary includes.preventing the spread of disease-causing organisms.Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment.On 6/17/26 at 1:38 PM, during a telephone interview the Resident Representative (RR) for Resident #1 reported that she complained that the facility did not provide a clean, sanitary environment and confirmed observations of houseflies, maggots (larva of houseflies) and gnats in the resident's room.On 6/17/26 at 3:40 PM and again at 5:00 PM, observations revealed a housefly in the lobby flying around Resident #2 repeatedly landing on his hands, arms and face. Resident #2 had a primary diagnosis of cerebral palsy and was not able to speak or move his hands/arms in a meaningful way or swat the housefly away.On 6/17/26 at 3:50 PM, observation and interview with Resident #1 revealed there was a housefly in the resident's room which distracted her during interview and she swatted at it repeatedly. The State Agency (SA) was able to speak limited conversational Spanish, coupled with the use of cellular telephone for translation, was able to have a conversation with Resident #1, who was neat, clean, and free from malodorous smells. Her demeanor was pleasant, calm and welcoming. She was able to understand and answer simple questions in Spanish.On 6/17/26 at 4:00 PM, observation and interview with Resident #4 in the hallway (100 Hall) and lobby revealed a housefly that repeatedly landed on her hands, arms and purse as she attempted to retrieve an item from her purse. Resident #4 swatted at the fly and confirmed that the fly was irritating her.On 6/17/26 at 4:10 PM, observation and interview with Resident #3 in the hallway (300 Hall) and lobby revealed a housefly flying around her and landing on her arms and hands with the resident swatting the fly and attempting to shoo the fly away. Resident #3 reported, The flies and the gnats are bad and confirmed that the pests annoyed and irritated her.On 6/18/26 at 1:20 PM, during observation and interview with the RR for Resident #2 in the resident's room revealed the RR reported repeated observation of pests, specifically houseflies, gnats and spiders, in the resident's room. Observation revealed a dead spider in a cobweb in the bottom right corner of the resident's room (corner under the window on the right of the window when viewed from the doorway into the room).On 6/18/26 at 1:35 PM, during interview with the Housekeeping Accounts Manager confirmed the dead insect observed in the room of Resident #2 looked like a spider. On 6/18/26 at 2:22 PM, observation and interview with Resident #6 revealed a housefly in the resident's room and the resident stated that he had not been impressed by the housecleaning or cleanliness of his room and that the houseflies bothered him. The SA observed a strong urine smell in the hallway (100 Hall) outside the resident's room which was very strong in his room. Resident #6 stated that he thought he had acclimated to the odor but said that he was able to see the urine on the floor coming out from under his bed and running along the wall under the window approximately four (4) feet to the corner.On 6/18/26 at 4:10 PM, during interview the Director of Nurses (DON) confirmed that contracted pest control service would visit and provide treatment if notified of pests in the building.On 6/18/26 at 4:40 PM, an interview with the Administrator confirmed that the contracted pest control service would visit and provide treatment if notified of pests in the building.On 6/18/26 at 5:00 PM, during an interview with the Infection Preventionist (IP) she confirmed that she had observed houseflies in residents' rooms and in common areas. Record review of the admission Record for Resident #1 revealed the facility admitted the resident on 6/11/25 and the resident had diagnoses of senile degeneration of brain, dementia, Alzheimer's Disease, anxiety, (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	restlessness and agitation.Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 3/20/26 for Resident #1 revealed a Brief Interview for Mental Status (BIMS) score as 0 which indicated severe cognitive impairment.Record review of the admission Record for Resident #2 revealed the facility admitted the resident on 5/31/18 and the resident had diagnoses of cerebral palsy, anxiety and adult failure to thrive.Record review of the Quarterly MDS with an ARD of 5/13/26 for Resident #2 revealed the facility assessed the resident unable to participate in interview and documented memory problems and severe impairment of cognitive skills for daily decision making.Record review of the admission Record for Resident #3 revealed the facility admitted the resident on 12/09/16 and the resident had diagnoses of osteoarthritis, diabetes and anemia.Record review of the Annual MDS with an ARD of 3/29/26 for Resident #3 revealed the facility assessed the resident's BIMS score as (15) which indicated resident #3 was cognitively intact.Record review of the admission Record for Resident #4 revealed the facility admitted the resident on 2/27/15 and the resident had diagnoses of hemiplegia and hemiparesis following cerebrovascular disease and Parkinson's Disease.Record review of the Annual MDS with an ARD of 5/20/26 for Resident #4 revealed she had a no BIMS score and documented no memory problem and no impairment of cognitive skills for daily decision making.Record review of the admission Record for Resident #6 revealed the facility admitted hm on 3/06/26 and he had diagnoses of heart failure, sepsis (unspecified organism acute infection present on admission), retention of urine, stage 3 chronic kidney disease, and stage 3 pressure ulcer of right button (present on admission).Record review of the Significant Change MDS for Resident #6 with an ARD of 5/21/26 revealed a BIMS score of 13, which indicated the resident was cognitively intact.