STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyards Comm Living Center	907 East Walker Street Fulton, MS 38843

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 41878 Based on Resident Representative and staff interviews, record review, and facility policy review, the facility failed to make prompt efforts to resolve a grievance and communicate the steps towards a resolution of the grievance concerning call lights not being answered timely for two (2) of five (5) monthly Grievance/Concern Logs reviewed. Findings include: Record review of facility's policy titled, Call Light, Use Of, dated 2/12/07 and revised on 11/15/19, revealed, It is the policy of this facility to have an adequately equipped communication system that allows residents to call for staff. Purpose: 1. To respond promptly to resident's call for assistance. 2. To assure call system is in proper working order. The policy also revealed, 1. All personnel should be aware of call lights at all times. 2. Answer call lights promptly whether or not you are assigned to the resident. 6. Answer call lights in a prompt, calm, courteous manner, turning off the call light as soon as you enter the room. Record review of facility's policy titled, Resident Rights, dated 7/24/23, revealed, Policy Statement: Employees shall treat all residents with kindness, respect, and dignity Policy Interpretation and Implementation 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to .: u. voice grievances to the facility, or other agency that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal; v. have the facility respond to his or her grievances . Record review of facility policy titled, Grievances and Complaints, dated 2/14/23, revealed, Social Services will act as the grievance officer for the facility and oversee the grievance process.All grievances will be reported to Social Services and Social Services will follow the following procedure to investigate and work to resolve the grievance .Step 1 Upon receipt of a grievance, Social Services will complete a written report within 5 working days of the filed grievance and determine what corrective actions, if any, should be taken. If the grievance is related to any form of abuse or harassment, the administrator must be notified immediately. Step 2 Social Services must notify the person who filed the grievance, within 10 working days of the filed grievance, in the form of a report. Copies of this report will be available to the person filing the grievance at any time . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. Building B. Wing	08/14/2024

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/13/24 at 5:40 PM, Resident #2's Resident Representative revealed the call light for Resident #2 was not being answered timely and that she had filed a grievance regarding this issue. She stated the resident was unable to care for her own needs and needed the staff to respond timely, and if staff members were available to be sitting at the desk, they should be available to answer the light. During an interview on 8/14/24 at 1:20 PM, the Social Service Director revealed she was the person responsible for overseeing the grievance process and she would have been the one to have gotten the grievance from the family. She confirmed the issue with the call lights not being answered timely was mentioned several times also in the Resident Council meetings as well as on the Grievance Log. She stated it was the residents' right to have their concerns addressed, and due to staffing changes, the facility failed to ensure the proper department was aware of the grievance, failed to make prompt efforts to resolve the concern, and failed to communicate the steps being taken towards the resolution for the call lights not being answered timely. During an interview on 8/14/24 at 1:30 PM, the Interim Director of Nursing (DON) revealed it was the residents' right to have any grievance addressed through the grievance process. She confirmed the grievance of the call lights not being answered timely was expressed during the Resident Council meetings as well as on the Monthly Grievance Log and the facility failed to resolve this grievance and communicate the solution with the residents and/or the family who may have filed a grievance. Record review of Monthly Grievance/Concern Log for May 2024 and for June 2024 revealed the grievance for the call lights not being answered timely. Record review of Resident Council Minutes revealed for the months of March 2024 and June 2024 call lights not being answered timely was voiced as a grievance. Record review of Resident Council Minutes for May 2024 revealed Old Business (Follow up on last month's minutes and identify staff person responsible) as Nursing: Call lights not being answered in a timely manner during 3-11 shift. There were no minutes from April 2024's meeting due to inability to locate, but this indicated there was a concern for the previous month. Record review of the facility's Performance Improvement Plan (PIP) dated 7/25/24, revealed Problem: Missing Resident Council Minutes for the month of February 2024 and April 2024. Plan of Correction: Activity Director (AD) resigned on 7/24/24. New AD in place as of 7/25/24. Resident Council Meeting Minutes will be completed monthly by AD and over seen by Social Service Director (SSD). Resident Council Meeting Minutes will be monitored by SSD/AD and or ADMIN monthly x 3 months. This was signed by the Social Service Director.

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 41878 Based on observation, staff and resident interviews, record review, and facility policy review, the facility failed to protect the resident ' s right to be free from physical, verbal, and mental abuse by staff for one (1) of three (3) residents reviewed for abuse. Resident #1 Findings include: Record review of facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 10/2022, revealed, Policy Statement: Residents have the right to be free from abuse .This include but is not limited to verbal, mental, or physical abuse Policy Interpretation and Implementation .5. Establish and maintain a culture of compassion and caring for all residents . Record review of facility policy titled, Freedom from Abuse, Neglect, and/or Exploitation Prevention Plan Education, with revision date of 11/14/17, revealed, The resident has the right to be free from abuse .by anyone, including, but not limited to facility staff . Following are relevant definitions provided by CMS (Centers for Medicare and Medicaid Services): Abuse - The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Verbal abuse - The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents . Physical abuse - Includes hitting, slapping, pinching, and kicking . Mental abuse - Includes, but is not limited to, humiliation, harassment, threats of punishment . Psychosocial harm - Include but are not limited to extreme embarrassment, ongoing humiliation, degradation as a human being. Willful - the individual must have acted deliberately, not that he/she must have intended to inflict injury or harm . Record review of facility policy titled, Resident Rights, dated 7/24/23, revealed Employees shall treat all residents with kindness, respect, and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . c. be free from abuse, neglect, misappropriation of property, and exploitation . During an interview on 8/13/24 at 8:45 AM, the Corporate Interim Director of Nursing (DON) revealed on 8/10/24, there was an allegation of abuse that alleged Certified Nursing Assistant (CNA)#1, who had only been an employee at the facility for approximately two weeks, abused Resident #1 while providing care. CNA #2 was a witness to this abuse and immediately reported the incident to the Assistant Director of Nursing (ADON). CNA #1 refused to write a statement on what occurred. She was suspended immediately and has since been terminated. The DON stated this was reported to the State Agency (SA), Attorney General's Office, Local Police, Medical Doctor, and the Resident's Representative and an investigation was being done. She stated Resident #1 was physically hurt, upset, embarrassed and humiliated about what happened and he considered leaving the facility because he was afraid. She stated this was Resident #1's home and to know he was considering leaving was upsetting to her and it was an indicator of how afraid he felt. She confirmed that each resident has the right to be free from abuse and the facility failed to protect this resident from physical, verbal, mental abuse and psychosocial harm by an employee of the facility. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview and observation of Resident #1 on 8/13/24 at 10:10 AM, revealed the resident in his room sitting in his motorized wheelchair. Contractures of upper and lower extremities was noted. He was smiling and talking and when asked about any incidents that had occurred in the facility, he immediately became wide-eyed and grimaced and stated a CNA hurt him and talked to him in a bad way. He stated he was embarrassed to tell what happened since it was awful. He stated he had never been treated that way before and had not been treated that way since. He expressed he was embarrassed to say what was said but then he continued and said a few days ago he was wet and needed to be changed and CNA #1 told him over and over again that he pissed on his shirt. He stated he felt humiliated and embarrassed that she would say that when he could not control that his shirt was wet. He stated she told him she had a child at home with my issues. He continued speaking and said when he was in the bed getting changed, CNA #1 hit him extremely hard with her open hand in his private parts and said that will make you relax. He stated he tried to call out how bad that hurt, but was unable to get the words out, then she grabbed his nipples one in each hand and pinched them hard and quick several times and he was saying owwww in pain. He stated that CNA #2 was also in the room during this and she heard and saw what CNA #1 did and told her to stop hurting me, and she did stop but then laughed about it. He stated he was afraid, embarrassed, and hurt and he had pain for several hours after it happened. He stated he was not sure if he received pain medicine when it happened, but he did take his pain medicine when he needed it. He stated he loved living in the facility, but after this occurred, he wanted to leave since he no longer felt safe and only decided to stay when they reassured him that CNA #1 would not be back. (continued on next page)

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	255212	A. Building B. Wing	08/14/2024

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/13/24 at 11:15 AM, CNA #2 revealed that on 8/10/24, she was working on the hall with CNA #1 who was a new employee at the facility. That morning before lunch, she went to assist CNA #1 with Resident #1's care since he was a two-person assist and a lift was used for transfers. The resident had taken his fluid pill and had a heavy urine output that soaked through and got his shirt wet, and CNA #1 kept telling him over and over again that you have pissed this nice shirt, you have pissed this nice shirt and his face turned red and she could tell that he was embarrassed and humiliated. He was in his wheelchair and the lift was used to transfer him to the bed to be cleaned and changed. She stated she had worked with Resident #1 many times and knew that whenever the resident was transferred, he would tense up, and it would take him a few seconds to relax. She stated when he was on the bed, she told him to relax, everything is fine, you are safe, just breathe and we will get you cleaned up like she always told him so that he would know he was safe on the bed and not to worry. She stated she heard something like nuts mentioned and she thought it was from the TV and all of a sudden CNA #1 with an open hand and with a forcible swing, hit the resident between his legs and hit his testicles and said, Nuts! That will make you relax! She stated the force was so great that both of his legs flew up and he did not yell out but made a noise and winced and became red in the face like he was about to cry. She knew he was in pain and embarrassed. She stated this happened so quickly and out of the blue with no warning. She told CNA #1 not to hit the resident and she pressed the call light for assistance so she could stay with resident to ensure he was safe, but rounds were being made and the other staff did not come immediately. She reached for the resident's clean shirt and turned back to see CNA #1 pinching the resident's nipples with strong force, one in each hand so using both hands and the resident did a wince like expression and an owwwwwww sound and she knew he was in pain. She stated she told CNA #1 to stop and leave the resident alone and that treatment was uncalled for. She did stop but stood there and laughed while he was in pain. CNA #1 told the resident she had a child at home with issues like you have. She stated CNA #1 did all of this harm to the resident within seconds. They got Resident #1 in his chair and she reported this incident immediately to Registered Nurse (RN) #2 and then to the Assistant Director of Nursing (ADON). About five minutes had passed and she went back to check on the resident and he told her he was still having some pain and he was embarrassed that this occurred and she told him that none of that was his fault and CNA #1 was wrong to do it. He told her he was scared she would do this again and he did not want to be near her and CNA #2 reassured him that she was gone and would not be back. She stated she had been in-serviced on abuse and neglect but she never thought she would actually see it. She stated she was bothered how CNA #1 harmed him and laughed while he was in pain. She stated she had spoken with the resident several times since this occurred and at first, he wanted to leave the facility because he did not feel safe but wanted to stay since he found out that CNA #1 would not return. She stated Resident #1 was very intelligent but had a childlike innocence and was so trusting and she felt that he was broken-hearted with this treatment. An interview with the Social Service Director (SSD) on 8/13/24 at 2:30 PM, revealed when this incident was reported by CNA #2, she was notified and interviewed Resident #1. He told her what had happened, how it hurt, and how it made him feel embarrassed and nervous. He also told her he wanted to leave the facility because he was afraid. She and the ADON stayed with him to try to decrease his anxiety and he did calm down when he knew that CNA #1 would not be back to the facility and could not harm him again. (continued on next page)

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	255212	A. Building B. Wing	08/14/2024

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/14/24 at 1:45 PM, RN #2 revealed she was working when the incident occurred. CNA #2 reported it to her and then reported it to the ADON. She stated she immediately checked on Resident #1 and he was hurting, upset, and afraid and said he did not want CNA #1 around him and she told him CNA #1 would not be back. She stated he was uncomfortable but did not require additional medications than he had already received. An interview on 8/14/24 at 2:00 PM, with the ADON revealed she was in the facility when this occurred and CNA #1 was immediately suspended and sent out of the facility. The provider was notified and ordered the resident a medication for anxiety if it was needed. A body audit was completed and no bruising or open areas were present. The resident said he was hurt and embarrassed and he was afraid CNA #1 would do this again. THe ADON stated she reassured Resident #1 that CNA #1 would not be back. Attempted to contact CNA #1 by phone on 8/13/24 at 11:45 AM (message left), 12:50 PM, 2:44 PM, and on 8/14/24 at 8:15 AM (message left). There was no answer or return of call from the messages left. Record review of Social Service Director's Progress Note dated 8/10/24 at 12:00 revealed, Was notified by ADON that a CNA had popped resident in his private area and pinched his nipples. SSD interviewed resident for any trauma and psychosocial. Resident stated what happened and that he was anxious about what happened and that he did not want her near him. Resident was comforted by SSD and ADON and assured him that would not happen again and that she would not be around him. Resident stated he felt safe here, just nervous. ADON notified MD and got Vistaril ordered for resident to help calm him down. Police Dept notified and report filed. Ombudsman notified and family notified. Resident family was thankful for staff acting on the situation and stated they did not want her around him. Family assured that she would not be around him. Will continue to observe and monitor. Record review of ADON's note dated 8/10/24 revealed, This nurse was informed by a CNA that another CNA popped this resident on the nuts because he was too tense and needed to relax and that she also pinched his nipples. Resident is very anxious about the situation and does not want to have her near him again. This nurse sent CNA home and reported to Administrator and RNC (Regional Nurse Consultant) and SSD. Notified RP and MD. MD gave new order for Vistaril 25 mg (milligrams) every 6 hours prn (as needed) x 14 days for anxiety. RP aware Record review of PHQ-9 Version 3 (which stated responses to PHQ-9 can indicate possible depression) dated 8/10/24, revealed, Resident denies any depression. Resident does state he is feeling nervous after incident. Resident also states he is embarrassed. Resident was calmed down by SSD and ADON by talking about different things like weather, tv shows, and music. MD notified for Vistaril to help calm resident down. This was signed by Social Service Director. Record review of Pain Evaluation dated 8/10/24 at 12:45 PM, revealed, Have you had pain or hurting at any time in the last 5 days? Response - Yes. Date of pain onset listed as 8/10/24. Description of pain was aching and tender. How much of the time have you experienced pain or hurting over the last 5 days? Response - Occasionally. Has the resident had any of the following changes in daily activities or habits? Response - Changes in mood/emotions (e.g. anger, crying, depressed, etc.) Check box for each of the following nonverbal/noncognitive signs which could indicate the presence of pain. Response - Facial expressions - grimacing/distorted face. Conclusion - Pain management intervention is necessary, refer to resident plan of care. (continued on next page)

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	255212	A. Building B. Wing	08/14/2024

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of Police Department Incident Report revealed an incident date of 8/10/24 with Resident #1 at the facility. The review of the report's narrative revealed, On Saturday, August 10, 2024 (Proper name removed) Police Department was dispatched to (Proper name of facility removed) for a possible abuse to a resident by an employee at their facility. (Proper name of CNA #2 removed) stated she witness another CNA (Proper name of CNA #1 removed) abuse (Proper name of Resident #1 removed) and (proper name of CNA #1 removed) proceeded to hit him in his testicles while changing him. (Proper name of CNA #2 removed) told him to relax and breath that he was safe on the bed. (Proper name of CNA #1 removed) told him Nuts! That will make you relax! and proceeded to pinch (proper name or Resident #1) nipples. (CNA #2) stated that due to the fluid pills daily so he urinated heavily and wet his shirt and (CNA #1) constantly said to him you have pissed this nice shirt. (CNA #2) advised that she could tell it embarrassed him and then (CNA #2) reported the incident to management. Record review of Admission Record revealed the facility admitted Resident #1 initially on 11/3/23, and the most recent admission was 7/9/24. His diagnoses included cerebral palsy, contracture of left wrist, right wrist, right ankle and foot, and left ankle and foot. Record review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact.

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	255212	A. Building B. Wing	08/14/2024

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 41878 Based on resident and staff interview, record review, and facility policy review, the facility failed to control pain for a resident who was experiencing moderate to intense pain for one (1) of three (3) residents reviewed for pain medication administration. Resident #3 Record review of facility policy titled Medication Administration - General Guidelines dated 8/25/14, revealed, .Medications are administered as prescribed in accordance with good nursing principles and practices .2. Administration . b. Medications are administered in accordance with written orders of the attending physician . During an interview on 8/13/24 at 9:10 AM, Resident #3 revealed she had Multiple sclerosis, Lupus, Arthritis, and Chronic pain and was on a pain medication regimen every four hours around the clock and this regimen kept her pain controlled, but if I miss even one dose, it sets me back for a week. She revealed that in June, her medication was not available, and the nurses gave her a different medication until hers was received from the pharmacy and even though it helped the pain, it did not help as much as her ordered medication did. She stated the most recent time was about a week ago and she waited until her medication was available so she could have it as soon as it arrived, and during that time she was experiencing moderate pain. She stated the nurses tried to explain the situation and why the medication was not available, but their explanation did not help her pain. During an interview with Registered Nurse (RN) #1 on 8/13/24 at 2:30 PM, revealed recently when she was assigned to Resident #3 the medication was not available for the 4:00 AM nor the 8:00 AM dose. Resident #3 was having pain and her pain level was nine (9) when the noon dose was administered. During an interview on 8/14/24 at 1:30 PM, the Director of Nurses (DON), acknowledged there were times the resident did not receive her pain medication as ordered because it was unavailable in the facility which led to Resident #3 missing two doses of her medication. On 08/06/24, the resident missed her 4:00 AM and her 8:00 AM doses of her pain medication which led to pain during that time with a documented pain level score of nine (9) when the dose was administered which indicated intense pain. Record review of Order Summary Report revealed an active order written on 6/4/24 for Oxycodone 15 milligram (MG) one tablet by mouth every four hours related to chronic pain syndrome. Record review of the August 2024 Electronic Medication Administration Record (EMAR) revealed Rate level of pain from 0-10 with (1) being the least and 10 being the most intense. On 8/6/24, the resident did not receive her 4:00 AM and 8:00 AM scheduled pain medication. The resident did receive the 12:00 noon dose and at that time the pain level was documented as 9, which was the only time in the month of August that pain level was that high. Record review of the August 2024 EMAR revealed a pain level on 8/5/24 night shift of 4 and the pain level on 8/6/24 day shift was 5 indicating pain for resident. Pain level on 8/6/24 at 12:00 noon when medication was administered after the two missed doses was 9 which indicated intense pain. (continued on next page)

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	255212	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0697 Level of Harm - Actual harm Residents Affected - Few	Record review of Admission Record revealed the facility admitted Resident #3 on 1/16/24. Her diagnoses included Multiple sclerosis, Lupus, and Chronic pain syndrome. Record review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/12/24 revealed a Brief Interview for Mental Status (BIMS)score of 15 which indicated the resident was cognitively intact.

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F 0755 Level of Harm - Actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 41878 Based on resident and staff interview, record review, and facility policy review, the facility failed to have available and administer an ordered medication for pain control for one (1) of three (3) residents reviewed for pain medication administration. Resident #3 Findings include: Record review of facility policy titled Medication Administration - General Guidelines dated 8/25/14, revealed, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. 2. Administration: . b. Medications are administered in accordance with written orders of the attending physician. During an interview on 8/13/24 at 9:10 AM, Resident #3 revealed there had been times in June 2024 and August 2024 that she did not receive her pain medication as ordered due to it not being available in the facility. She stated she had Multiple sclerosis, Lupus, Arthritis, and chronic pain and was on a pain medication regimen every four hours around the clock and this regimen kept her pain controlled, but if I miss even one dose, it sets me back for a week. She revealed that in June, her medication was not available and the nurses gave her a different medication until hers was received from the pharmacy and even though it helped the pain, it did not help as much as her ordered medication did. She stated the most recent time was about a week ago and she waited until her medication was available so she could have it as soon as it arrived, and during that time she was experiencing moderate pain. She stated the nurses tried to explain the situation and why the medication was not available, but their explanation did not help her pain. An interview with Registered Nurse (RN) #1 on 8/13/24 at 2:30 PM, revealed there had been times when Resident #3's pain medication was not available when it was due. This recently occurred when she was assigned to the resident and the medication was not available for the 4:00 AM nor the 8:00 AM dose. She stated she notified the Director of Nursing (DON) who obtained the prescription and picked up the medication from the pharmacy. She revealed that when the medication arrived, she gave the resident her noon dose. She stated the resident did not express that she was experiencing uncontrolled pain and she appeared to be tolerating missing the medication without distress, but she was having pain and her pain level was nine (9) when the noon dose was administered She explained that the resident received the pain medication every 4 hours and pharmacy only sent a card of 30 for this resident, and that amount did not last for many days. Also, if a medication was wasted due to being dropped, the resident would be one pill short and would run out even quicker. She acknowledged the medication should have been available as ordered for the resident's pain control. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255212	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyards Comm Living Center	907 East Walker Street Fulton, MS 38843

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 0755 Level of Harm - Actual harm Residents Affected - Few	On 8/14/24 at 1:30 PM, during an interview with the Director of Nurses (DON), she acknowledged there were times the resident did not receive her pain medication as ordered because it was unavailable in the facility. She stated in June, the resident was out of her ordered pain medication, so they spoke with the doctor and obtained an order to give a medication that was available in the emergency kit, and it eased her pain but not as well as her ordered medication. They put a new process in place at that time to prevent that from occurring again, but on 08/06/24, the resident missed her 4:00 AM and her 8:00 AM doses of her pain medication which led to pain during that time with a documented pain level score of nine (9) when the dose was administered which indicated intense pain. She stated it was determined that their process failed since the resident received six tablets each day and the medication card only lasted 5 days. The facility failed to reorder this timely which led to the resident missing two doses of her medication. She stated the facility has a medication emergency kit that could be used with a physician's order, but Resident #3's ordered medication was not stocked in that system due to it being a stronger medication than others. The resident used medication from the emergency kit in June but did not on 8/6/24 even though it was available if she had wanted it. She confirmed that all ordered medications should be available and administered as prescribed and the facility failed to ensure that pain medication was available to meet the needs of Resident #3. Record review of Order Summary Report revealed an active order written on 6/4/24 for Oxycodone 15 milligram (MG) one tablet by mouth every four hours related to chronic pain syndrome. Record review of the August 2024 Electronic Medication Administration Record (eMAR) revealed Rate level of pain from 0-10 with (1) being the least and 10 being the most intense. On 8/6/24, the resident did not receive her 4:00 AM and 8:00 AM scheduled pain medication. The resident did receive the 12:00 noon dose and at that time the pain level was documented as 9, which was the only time in the month of August that pain level was that high. Record review of August 2024 EMAR revealed a pain level on 8/5/24 night shift of 4 and the pain level on 8/6/24 day shift was 5 indicating pain for resident. Pain level on 8/6/24 at 12:00 noon when medication was administered after the two missed doses was 9 which indicated intense pain. Record review of EMAR revealed the resident did not receive her pain medication for the 8:00 PM dose on 6/16/24 and also did not receive the 12:00 midnight, 4:00 AM, or 8:00 AM doses on 6/17/24. Record review of Individual Patient's Narcotics Record with start date of 8/1/24 and end date of 8/6/24 revealed the resident received last dose of these 30 tablets at midnight on 8/6/24. Record review of Controlled Drug Receipt/Record/Disposition Form revealed the resident received first dose from this card on 8/6/24 at 11:20 AM. Record review of Admission Record revealed the facility admitted Resident #3 on 1/16/24. Her diagnoses included Multiple sclerosis, Lupus, and Chronic pain syndrome. Record review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/12/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.