

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255212	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Courtyards Comm Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>41878</p> <p>Based on staff and resident interviews, record review, and facility policy review, the facility failed to honor a resident's right to be treated with dignity and respect for two (2) of four (4) residents reviewed for resident rights. Resident #1 and #3</p> <p>Findings include:</p> <p>Record review of the 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: a. a dignified existence; b. be treated with respect, kindness, and dignity.</p> <p>Resident #1</p> <p>During an interview on 12/11/24 at 11:50 AM, Resident #1 stated there was an incident where she was made to feel like a nobody and was pushed in her wheelchair by Registered Nurse (RN) #1. She stated she was putting the phone back at the nurses' station and was speaking to the Dietary Manager when RN #1 came up and told her, in a very rude way, to get out of that area because only staff were allowed there and then pushed her wheelchair with force. Resident #1 stated she told RN #1, Don't push me and don't touch me or my chair!. She stated she also told RN #1 that if the rules were changed, they needed to inform the residents since she had been going behind the desk to use the phone since she had been in the facility. She revealed she continued by telling RN#1 that this was her home and not a prison. She stated she was not physically harmed but felt upset that she was scolded like that.</p> <p>An interview with the Dietary Manager on 12/11/24 at 1:45 PM confirmed she was at the nurses' station when the incident between Resident #1 and RN #1 occurred, and she reported this to the social worker. She confirmed that Resident #1 was returning the phone to the desk and RN #1 came up and told her she could not be back there. She stated that the resident told RN#1 that she was just putting up the phone and RN#1 said you cannot be behind the desk. She revealed that RN#1 squeezed between Resident #1's chair and the nurses' station wall which might have pushed Resident #1's chair, but she did not see RN #1 intentionally push the chair. She stated the resident was visibly upset and said she felt like a prisoner and that she had rights, then rolled back to her room. She stated she understood why the resident was so upset since this was her home and she had every right to use the phone. She stated that RN#1 was not yelling but the way it came out did sound rude and should have been worded differently.</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 255212	Facility ID: 255212 If continuation sheet Page 1 of 5

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a phone interview on 12/11/24 at 4:45 PM, RN#1 confirmed she upset Resident #1 and stated that she never meant to hurt Resident #1's feelings or to make her feel bad in any way. She stated she was speaking to the staff and not directly to the resident to remind staff of the confidential information that had to be protected. She stated she did not push the resident, and the resident propelled herself to her room. She revealed she did not realize there was a concern until she was told that Resident #1 was upset so she and the Director of Nursing (DON) went to apologize immediately. She stated she realizes now that even though she was not speaking directly to the resident, the resident was there and heard everything that was said. She admitted that it was not respectful to speak about that when the resident was there and knew she was the one being talked about. She stated that each resident should be treated with dignity and respect and even though she did not mean to upset the resident, she could see how that situation caused Resident #1 to be upset with hurt feelings.</p> <p>During an interview on 12/12/24 at 9:45 AM, Certified Nursing Assistant (CNA) #1 stated she was at the nurses' station when Resident #1 came to return the phone and was speaking to the Dietary Manager. She confirmed that she heard RN #1 tell Resident #1 that she could not be behind the desk, and she needed to get out from behind there. She stated that RN#1 did not yell, but had a blunt, stern, and matter of fact tone. She stated she was charting and did not see RN#1 push her chair. She confirmed that the resident was upset and angry about the incident.</p> <p>An interview with the Administrator on 12/12/24 at 10:45 AM confirmed each resident had the right to be treated with dignity and respect. She confirmed the facility failed to ensure that Resident #1's rights were honored when she felt she was scolded and reprimanded by a staff member.</p> <p>Record review of Resident #1's Admission Record revealed the facility admitted her on 1/16/24 with medical diagnoses that included Multiple Sclerosis and Systemic Lupus Erythematosus.</p> <p>Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/7/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated this resident was cognitively intact.</p> <p>Resident #3</p> <p>During a record review of the Resident Council Meeting minutes, it was revealed that during the meeting on 11/26/24 there was a concern involving Resident #3. The entry on the Resident Council minutes sheet read as follows: (Resident #4) let us know that a nurse assistant was ugly to (Resident #3) on 11/23/24 while the residents were watching the Alabama football game .I met with DON alongside (Administrator) to report the issue. They stated they would open an investigation and talk with the CNA (Certified Nursing Assistant). Resident #4 said the aid told Resident #3 she was tired of dealing with him. This was signed by the Activity Director on 11/26/24.</p> <p>An interview with the Activity Director on 12/11/24 at 12:15 PM confirmed that during the Resident Council meeting on 11/26/24, Resident #4 was asked by Resident #3 to tell of the incident that occurred. She stated Resident #4 said that he and Resident #3 were watching a football game in the dining room and a CNA was rude to Resident #3 telling him that she was tired of working with him. She stated that while Resident #4 was telling of the incident that had occurred, Resident #3 was teary eyed. The Administrator was in the meeting with her, and they both went and reported it to the Director of Nursing and was told it would be investigated.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/11/24 at 1:30 PM, Resident #4 confirmed that he witnessed an incident where a CNA was rude to Resident #3. He stated he does not know which CNA it was. He stated this occurred during the Alabama football game on Saturday 11/23/24 and he and Resident #3 were in the dining area watching the game. Resident #3 was leaning in his chair, and he went to get staff because he was concerned Resident #3 would fall. The CNA told Resident #3 something like she was damn tired of doing this s**t and this upset Resident #3. He stated that the next evening, Resident #3 came to him and was still upset asking if he would mention this in the next Resident Council meeting. He stated he was not sure what the facility did for this situation, but he knew they were aware it happened.</p> <p>An interview with Resident #3 on 12/11/24 at 1:40 PM, confirmed that he was in the dining room watching a football game and was needing a pillow so Resident #4 went to get the staff. He thought it was CNA #2 that came to check on him and he asked her for a pillow, and she said, No, you don't need that pillow and I'm tired of doing this and did not get it for him. He stated she did not cuss at him, but it did upset him, and he thought, Woah, oh no, that's not good and she should help. He stated it did upset him, that he needed something to help him be more comfortable and that care was denied. He stated it was rude and disrespectful and not sure if abusive, but it was not right and it did make me get pretty down and upset. He confirmed that Resident #4 witnessed this and the next day after the incident he was still bothered about it and asked Resident #4 to mention it in the Resident Council meeting since he did not feel comfortable talking about it.</p> <p>During a phone interview on 12/11/24 at 4:00 PM, CNA #2 revealed she was at the desk and Resident #4 came to the desk and said something was wrong with Resident #3 because he was leaning and falling from his chair. She revealed that she went to the dining room and there was no concern with Resident #3's position. She revealed that she thought Resident #3 was upset due to a phone conversation with his mother and not her or the care. She stated she did not tell the resident she was tired of caring for him and would not say that to any resident.</p> <p>An interview with the Administrator on 12/12/24 at 10:45 AM revealed she was aware of what was reported regarding a CNA being ugly to Resident #3 because it was reported in the Resident Council, and she was in the meeting. She stated she and the Activity Director informed the Director of Nursing who spoke with the staff involved and could not determine whether any abuse occurred. She stated that the staff interviewed told her that Resident #3 was upset since it was Thanksgiving time, and his mother had changed the date she was going to pick him up. She stated after speaking to the two staff members, she felt there were no concerns since she was told he was only upset because his mother was not going to pick him up for Thanksgiving.</p> <p>Record review of Resident #3's Admission Record revealed the facility admitted the resident on 11/3/23 with medical diagnoses that included Cerebral Palsy.</p> <p>Record review of Resident #3's MDS with an ARD of 10/11/24 revealed a BIMS score of 14 which indicated this resident was cognitively intact.</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>41878</p> <p>Based on staff and resident interviews, record review, and facility policy review, the facility failed to make prompt efforts to resolve and thoroughly investigate grievances from Resident Council meetings for eight (8) of the last nine (9) Resident Council meetings.</p> <p>Findings include:</p> <p>Record review of the 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. Grievance forms should be kept outside of the office, where residents, family members, and staff members can access them at any time. 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 .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 .</p> <p>During a record review of the Resident Council Minutes, it was revealed that during the meeting on 11/26/24 there was a concern involving Resident #3. The entry on the Resident Council Minutes sheet read as follows: (Resident #4) let us know that a nurse assistant was ugly to (Resident #3) on 11/23/24 while the residents were watching the Alabama game . I met with DON (Director of Nursing) alongside (Administrator) to report the issue. They stated they would open an investigation and talk with the CNA (Certified Nursing Assistant). Resident #4 said the aid told Resident #3 she was tired of dealing with him. This was signed by the Activity Director on 11/26/24.</p> <p>The record review of Resident Council Minutes revealed repeated concerns with staff's use of cell phones in the facility was a mentioned during the meetings held on 9/5/24, 9/11/24, 9/18/24, 9/26/24, 11/14/24, and 11/26/24. The concern for the staff turning call lights off and not providing requested care unless they were assigned to that resident was voiced during the meetings on 8/14/24, 9/5/24, 11/14/24, 11/26/24, and 12/5/24. Repetitive concerns of bed sheets not being changed were voiced on 7/24/24, 8/14/24, 9/5/24, 9/11/24, 9/18/24, 9/26/24, and 10/9/24.</p> <p>During an interview on 12/11/24 at 11:50 AM, Resident #1 revealed she attended the Resident Council meetings regularly. She stated there are grievances that continued to be a concern even though they were mentioned in the meetings often. She stated one of these areas was that some of the Certified Nursing Assistants (CNA) did not assist her with care unless they were assigned to her. She stated they say things like they don't have her and they will let her CNA know and that delayed receiving the needed care. She also stated another frequent grievance was that some staff were on their phones often and if they had time for that, they should have time to provide the care requested.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with the Activity Director on 12/11/24 at 12:15 PM confirmed that during the Resident Council meetings, residents had voiced grievances which included the staff being on their phones and the staff only providing care for the residents they were assigned to. She stated the grievances in the Resident Council meetings were listed on the meeting minutes form and were provided and signed off by each department so the concerns could be addressed and resolved. She stated part of the grievance process was to make sure the staff in the area of concern was aware so a solution could be implemented. Activity Director confirmed that during the Resident Council meeting on 11/26/24, Resident #4 was asked by Resident #3 to tell of the incident that occurred. She stated Resident #4 said that he and Resident #3 were watching a football game in the dining room and a CNA was rude to Resident #3 telling him that she was tired of working with him. The Administrator was in the meeting with her, and they both went and reported it to the Director of Nursing and was told it would be investigated.</p> <p>On 12/11/24 at 1:30 PM, dduring an interview, Resident #4 revealed he witnessed an incident where a CNA was rude to Resident #3. He stated he does not know which CNA it was. He stated this occurred during the Alabama football game on Saturday 11/23/24 and he and Resident #3 were in the dining area watching the game. He stated he was not sure what the facility did for this situation, but he knew they were aware it happened.</p> <p>An interview with the Administrator on 12/12/24 at 10:45 AM confirmed the facility failed to address the recurring grievances in Resident Council meetings concerning phone use by staff and staff not providing care for residents assigned to another staff member. She was aware of what was reported in the Resident Council meeting concerning Resident #3 since she was in the meeting. She stated she and the Activity Director informed the Director of Nursing that it was mentioned in resident council that Resident #3 had been talked to in a mean way and was denied care. She reported back to me that she had spoken with the staff involved and could not determine that any abuse had occurred. She informed me that the staff told her that Resident #3 was upset after a phone call to his mother. She stated after speaking to the two staff members, she felt there were no concerns since she was told he was only upset because his mother was not going to pick him up for Thanksgiving. She revealed the facility failed to develop a plan to correct the concerns and keep residents informed of the process towards a resolution. She admitted there had been concerns voiced in Resident Council meetings that had not been resolved and the residents were not informed of the steps taken to resolve the grievance. She stated any grievance should be investigated and steps should be taken to resolve the concern.</p> <p>Record review of Resident #1's Admission Record revealed the facility admitted her on 1/16/24.</p> <p>Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/7/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated this resident was cognitively intact.</p>		