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	05/21/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, facility document review, and record review, the facility failed to ensure comprehensive Activities of Daily Living (ADL) care plans were developed and implemented for two (2) of eighteen (18) residents reviewed. Specifically, the facility failed to develop a comprehensive ADL care plan addressing nail care needs for Resident #8 and failed to implement established ADL care plan interventions related to nail care for Resident #45.The scope and severity for this deficiency were cited at an E due to previous citations of F656 on the last two annual recertification surveys completed on 2/20/24 and 5/22/25 representing a pattern of deficiency. Findings include:Review of facility policy titled Care Plan Policy and Procedure with no date revealed, .Each resident's care plan will remain current and inform staff of resident's needs, strengths, goals and approaches.Resident #8Record review of Resident #8's ADL care plan, dated 10/29/2024, revealed the comprehensive care plan was not developed to include nail care.On 5/18/2026 at 11:46 AM, during an observation Resident #8's fingernails were observed to be approximately three-fourths (3/4) inch in length with jagged edges.Record review of the admission Record indicated Resident #8 was admitted to the facility on [DATE] with medical diagnoses that included mild vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety and need for assistance with personal care.Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/22/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 6, indicating Resident #8 had severe cognitive impairment.Resident #45Record review of Resident #45's skin integrity care plan, dated 11/6/2025, revealed, .Keep fingernails short.During an observation on 5/18/2026 at 3:15 PM, Resident #45's fingernails were observed to be approximately one (1) inch in length with jagged edges.Record review of the admission Record indicated Resident #45 was admitted to the facility on [DATE] with a medical diagnosis that included hypertensive heart disease without heart failure.Record review of the MDS with an ARD of 2/10/2026, revealed under Section C a BIMS score of 9, indicating Resident #45 had moderate cognitive impairment.During an interview on 5/20/2026 at 3:44 PM, the Minimum Data Set (MDS) Coordinator and the Director of Nursing (DON) confirmed Resident #8's ADL care plan had not been developed to address nail care needs and Resident #45's care plan interventions related to nail care were not implemented by facility staff. The DON confirmed nail care tasks were listed on the Kardex for Certified Nursing Assistants (CNAs) to document on shower days. Both nurses stated the purpose of the care plan was to guide staff in providing appropriate care for the residents.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, record reviews, and facility policy review, the facility failed to provide activities of daily living (ADL) care necessary to maintain personal hygiene for two (2) of sixty (60) residents observed. (Residents #8 and #45)The scope and severity for this deficiency were cited at an E due to previous citations of F677 on the last two annual recertification surveys completed on 2/20/24 and 5/22/25 representing a pattern of deficiency. Findings include:Review of the facility policy titled ADL Care of a Resident Policy and Procedure, undated, revealed, .Resident ADL care will be provided to the resident according to the individualized resident needs.Resident #8During an observation on 5/18/2026 at 11:46 AM, Resident #8's fingernails were observed to be approximately three-fourths (3/4) inch in length with jagged edges.During an observation and interview on 5/19/2026 at 1:26 PM, Licensed Practical Nurse (LPN) #1 confirmed Resident #8's fingernails were long with jagged edges. She further confirmed jagged fingernails could cause the resident to develop a skin tear that could lead to infection. When questioned regarding responsibility for nail care, she stated, Everyone is responsible unless the resident is diabetic.Record review of the admission Record indicated Resident #8 was admitted to the facility on [DATE] with medical diagnoses that included mild vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety and need for assistance with personal care.Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/22/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 6, indicating Resident #8 had severe cognitive impairment.Resident #45During an observation on 5/18/2026 at 3:15 PM, Resident #45's fingernails were observed to be approximately one (1) inch in length with jagged edges.During an observation and interview on 5/19/2026 at 1:15 PM, Resident #45 stated his fingernails had been cut that morning. He stated, Someone cut them this morning. They were twice as long yesterday.During an interview on 5/19/2026 at 1:20 PM, Registered Nurse (RN) #1 confirmed Resident #45's fingernails had been trimmed that day except for the thumbnails. She further confirmed residents with long fingernails and jagged edges were at increased risk for skin tears and infection.Record review of the admission Record indicated Resident #45 was admitted to the facility on [DATE] with a medical diagnosis that included hypertensive heart disease without heart failure.Record review of the MDS with an ARD of 2/10/2026, revealed under Section C a BIMS score of 9, indicating Resident #45 had moderate cognitive impairment.During an interview on 5/19/2026 at 2:44 PM, the Director of Nursing (DON) confirmed that fingernails should be kept clean and trimmed as needed. She stated, The Certified Nursing Assistants (CNAs) should trim them on shower days as needed unless the resident is diabetic. Diabetic nails are trimmed by the Registered Nurses (RNs).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, record review and facility policy review the facility failed to maintain infection control practices by failing to ensure respiratory equipment was stored in a sanitary manner to prevent contamination (Resident #30) and by failing to ensure soiled items were properly discarded (Resident #55) for two (2) of eighteen sampled residents.The scope and severity for this deficiency were cited at an E due to previous citations of F880 on the last two annual recertification surveys completed on 2/20/24 and 5/22/25 representing a pattern of deficiency. Findings Include: Review of the facility policy titled, Infection Control Policy and Procedure, undated, revealed Purpose: To establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Review of a statement typed on facility letterhead dated 5/21/26 and signed by the Administrator revealed, We do not currently have a specific Policy and Procedure for the nebulizer mouthpiece to be covered in a bag. Resident #30 An observation on 5/20/2026 at 9:17 AM revealed Registered Nurse (RN) #2 administered a nebulizer treatment to Resident #30. Prior to administration, the nebulizer mouthpiece was observed not stored in a protective bag and was not cleaned prior to use. On 5/20/2026 at 11:05 AM, RN #2 confirmed the mouthpiece was not in a protective bag. RN #2 acknowledged improper storage of the mouthpiece presented an infection control concern. During an interview on 5/20/2026 at 3:54 PM, the Administrator acknowledged the nebulizer mouthpiece should be stored in a protective bag and confirmed improper storage presented an infection control concern. Record review of Resident #30's Order Summary Report revealed an order with effective date of 5/7/2026, Albuterol Sulfate Nebulization Solution (2.5 MG (milligrams/3ML(milliliters) 0.083% 3 ml inhale orally via nebulizer four times a day for Shortness of Breath related to Mild Persistent Asthma, Uncomplicated; Primary Spontaneous Pneumothorax. Record review of Resident #30's Order Summary Report revealed an order with effective date of 5/7/2026, Pulmicort Suspension 0.5 MG/2ML (Budesonide) 2 ml inhale orally every 12 hours related to Mild Persistent Asthma, Uncomplicated; Primary Spontaneous Pneumothorax. Record review of admission Record revealed Resident #30 was admitted to facility on 5/7/2026 with diagnoses that included Encounter for Surgical Aftercare Following Surgery on the Nervous System, Unspecified Systolic (Congestive) Heart Failure, and Mild Persistent Asthma. Record review of BIMS (Brief Interview for Mental Status) Interview MDS 3.0 with effective date of 5/7/2026 revealed a BIMS summary score of 9 indicating Resident #30 is moderately cognitively (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	impaired. Resident #55 An observation from the hallway on 5/19/2026 at 1:59 PM revealed Resident #55 lying in bed. On the resident's floor were two soiled gloves lying near the door, two (2) separate unidentified clothing articles lying on the floor, and a pile of white bath towels containing a large amount of soiled incontinence wipes with a brown substance noted on the wipes. During an observation and interview on 5/19/2026 at 2:04 PM, Certified Nurse Aide (CNA) #1 entered Resident #55's room carrying a disposable blue pad. CNA #1 stated, I had to run and get a blue pad, and further stated, It's been a day, yeah, I know I'm going to need to get my mess cleaned up off the floor. CNA #1 confirmed that she had thrown the soiled items she used while rendering peri-care to the resident onto the floor instead of properly discarding them. She confirmed that this practice was unsanitary and posed an infection-control concern. During an interview on 5/19/2026 at 2:10 PM, the Infection Preventionist (IP) revealed that staff have been educated that, while providing peri-care, they are to place soiled items in bags and properly dispose of them. She revealed that it is never acceptable to put any items on the floor, as it could cause cross-contamination. During an interview on 5/19/2026 at 2:25 PM, the Director of Nursing (DON) confirmed that placing soiled items on the floor was unsanitary and posed an infection control concern. She revealed staff were expected to properly dispose of soiled items and stated it was never acceptable to place them on the floor. Record review of the admission Record revealed Resident #55 was admitted to the facility on [DATE] with diagnoses that included Major Depressive Disorder, and Systolic (Congestive) Heart Failure. Record review of the MDS with an ARD of 3/4/26 revealed a BIMS score of 03 which indicated Resident #55 was severely cognitively impaired.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review, and facility policy review the facility failed to ensure the residents were treated with dignity and respect by failing to maintain privacy during the provision of care for one (1) of 18 sampled residents. Resident #55 Findings include:Review of the facility policy titled, Residents Rights and Quality of Life Policy and Procedure undated, revealed All residents have the right to a dignified existence.An observation from the main hallway on 5/19/2026 at 1:59 PM revealed Resident #55 lying in bed, uncovered, with her incontinent brief and legs exposed. The privacy curtain was not drawn, and the room door remained open to the hallway. During the observation, hospice personnel and maintenance staff passed by the resident's room while the resident remained exposed, and the door remained open.An observation and interview on 5/19/2026 at 2:04 PM, Certified Nurse Aide (CNA) #1 entered Resident #55's room carrying a disposable blue pad. CNA #1 stated, I had to run and get a blue pad, and further stated, It's been a day. CNA #1 confirmed she left the room door open and acknowledged Resident #55 had been left exposed to individuals passing in the hallway. CNA #1 stated she should have closed the resident's door.During an interview on 5/19/2026 at 2:10 PM, Licensed Practical Nurse (LPN) #1 stated that no resident should ever be left exposed in that manner and the situation was totally not acceptable practice in the facility.An interview on 5/19/2026 at 2:25 PM, the Director of Nursing (DON) revealed that leaving Resident #55 exposed with the door open was a dignity concern and should not have occurred. The DON further stated the privacy curtain should have been drawn to provide Resident #55 with complete privacy.On 5/19/2026 at 2:40 PM, the facility Administrator revealed it is the facility's expectation that all residents' dignity be maintained and that resident room doors remain closed while care is being provided. The Administrator further revealed that this was not considered normal practice within the facility.Record review of the admission Record revealed Resident #55 was admitted to the facility on [DATE] with diagnoses that included Major Depressive Disorder, and Systolic (Congestive) Heart Failure. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/4/26 revealed a Brief Interview for Mental Status (BIMS) score of 03 which indicated Resident #55 was severely cognitively impaired.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, resident interview, staff interview, record review, and facility policy review, the facility failed to ensure a clean homelike environment for one (1) of 38 resident rooms. Resident #2Findings Include: Record review of facility policy titled Cleaning and Disinfection of Environmental Services revised August 2009 revealed, .14. Horizontal surfaces will be wet dusted regularly (e.g., daily, three times per week) using clean cloths moistened with an EPA-registered hospital disinfectant (or detergent). The disinfectant (or detergent) will be prepared as recommended by the manufacturer . In an interview on 5/18/2026 at 12:30 PM, Resident #2 stated that her room was dusty and she needed to clean it herself. Resident #2 stated she also needed to clean the bathroom. When asked if housekeeping staff cleaned her room, Resident #2 stated they only removed the trash. Resident #2 stated that she does not like her room to be dusty. Observations made on 5/18/2026 at 12:35 PM and again on 5/19/2026 at 3:50 PM of Resident #2's room revealed, heavy accumulations of dust on chest of drawers, radio, photo frames, overbed light, wardrobe, television, bathroom sink, bathroom light fixture, and baseboards. An observation and interview on 5/19/2026 at 4:00 PM, the Housekeeping Supervisor confirmed Resident #2's room appeared inconsistent with the facility's routine cleaning schedule. On 5/20/2026 at 3:52 PM, the Administrator confirmed the expectation of the facility is for resident rooms to be cleaned thoroughly and regularly. Record review of admission Record revealed Resident #2 was admitted to facility on 11/12/2025 with diagnoses of Chronic Obstructive Pulmonary Disease, Vascular Dementia, and Anxiety Disorder. Record review of the Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 4/10/2026 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 13 indicating Resident #2 was cognitively intact.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and facility policy review, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the resident's status for one (1) of eighteen (18) residents reviewed. (Resident #21)Findings include:Review of the facility policy titled Resident Assessment Policy and Procedure, undated, revealed, .The facility shall complete residents' assessments via MDS 3.0 according to the Resident Assessment Instrument (RAI) guidelines.Record review of Resident #21's Significant Change MDS assessment, with an Assessment Reference Date (ARD) of 7/21/2025, revealed under Section J1900C (Number of Falls Since Admission/Entry or Reentry or Prior Assessment - Major Injury), the assessment was coded to indicate the resident experienced a fall with major injury during the look-back period.Record review of Resident #21's progress notes and the facility Incident Log revealed no record of a fall with major injury for Resident #21. During an interview on 5/19/2026 at 3:00 PM, the Director of Nursing (DON) confirmed Resident #21 did not experience a fall with major injury and stated the MDS assessment had been coded incorrectly.During an interview on 5/21/2026 at 10:20 AM, the Minimum Data Set (MDS) Nurse confirmed Resident #21's Significant Change Assessment was incorrectly coded for a fall with major injury.During an interview on 5/21/2026 at 11:35 AM, the Administrator stated her expectation was for MDS assessments to be completed accurately and reflect the resident's status.Record review of the admission Record indicated Resident #21 was admitted to the facility on [DATE] with a medical diagnosis that included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side.