

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/07/2024
NAME OF PROVIDER OR SUPPLIER YAZOO CITY REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 925 CALHOUN AVENUE YAZOO CITY, MS 39194		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an onsite complaint investigation from 5/6/24 through 5/7/24 for CI MS #24937 related to Pressure Ulcers and CI MS #24949 related to an allegation of verbal abuse . Although, the current investigation resulted in no deficiencies being cited, the facility remains Out of Compliance with the standards for participation in Medicaid and Medicare due to deficiencies cited on the April 5, 2024 survey. On 5/6/24 the facility was licensed for 165 beds and the resident census was 143.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

05/14/2024