STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	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 CI MS #25237 On May 29 and May 30, 2024 the State Agency (SA) conducted an onsite complaint investigation CI MS #25237, for the facility's "self-reported" elopement of a resident. The elopement of the resident occurred on May 25, 2024 after midnight. The SA determined that the facility was not in compliance with the Standards for Participation in Medicare and Medicaid and Substandard Quality of Care (SQC) had existed from the time of the resident's elopement on May 25, 2024, until May 28, 2024 when corrective actions were completed. On May 29, 2024 the SA cited Immediate Jeopardy (IJ) deficiencies at a Scope and Severity (S/S) of "K" (Pattern) Past Non-Compliance (PNC). The facility had recently on April 05, 2024, received (IJ) citations in the same areas for lack of resident supervision related to elopement and failures with care planning. The additional (IJ) finding at a (S/S) of "K" constituted (SQC) and an Extended Survey was conducted on 05/29/24-05/30/24. The SA identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) at Past Non-Compliance (PNC) which began on 05/25/24 when the facility allowed a resident with delusions to leave the facility unsupervised and undetected. On 05/25/24 at approximately 2:00 A.M. the Licensed Practical Nurse (LPN #1) discovered that Resident #1 was missing and had disassembled the bedroom window and left the facility undetected through the disassembled window. The Certified Nursing Assistant (CNA	F 000	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 06/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	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	Continued From page 1	F 000		

#1) reported last seeing Resident #1 at 12:30 A.M. on 05/25/24. LPN #1 immediately contacted the facility Administrator (ADM), Director of Nursing (DON), the facility Medical Director (MD), Nurse Practitioners (FNP), Resident Relative (RR), facility Maintenance, and local Law Enforcement officials. A search by facility staff and Law Enforcement began at approximately 2:10 A.M. on 05/25/24. At approximately 5:45 A.M. on 05/25/24 the local Law Enforcement called the facility and reported that they had picked Resident #1 up at a store several miles from the facility and had taken him to the Dispatch Office to await the facility staff's arrival. The ADM and the DON picked Resident #1 up from the Dispatch Office at approximately 6:00 A.M. without incident. The DON began immediately assessing Resident #1's physical and mental condition on 05/25/24 at 6:00 A.M. The DON found Resident #1 to have no physical injury but he continued to voice delusional thoughts about leaving the facility to go to work. Since his return to the facility on 05/25/24 at approximately 6:00 A.M. Resident #1 repeatedly voiced to facility the need to leave and go to work. The facility placed Resident #1 on constant one to one (1:1) close observation on 05/25/24 at 6:15 A.M. Resident #1 will remain on 1:1 until anticipated discharge on 05/31/24 to a "locked" memory unit at another facility.

The facility's failure to provide appropriate supervision resulted in the elopement of Resident #1 and placed this resident and other residents with wandering and/or exit seeking behaviors in a situation which was likely to cause serious injury, harm, impairment, or death.

On 05/29/24 at 2:00 P.M. the SA notified the ADM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	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	Continued From page 2 of the IJ and SQC (PNC) and provided the facility with the IJ template. IJ and SQC at PNC existed at: 42 CFR (s) 483.25 (d) (1)(2) - Free of Accidents/ Hazard/Supervision/Devices (F689)-S/S="K" The facility provided an acceptable Removal Plan on 05/29/24, in which the facility alleged all corrective actions were completed to remove the IJ on 05/28/24 prior to the SA entering the building on 05/29/24. The SA determined the IJ was removed on 05/28/24, prior to the SA entering the building and the S/S for F689-Supervision was lowered from a "K" to an "E". On 05/29/24, the facility was licensed for 165 beds and the resident census was 149.	F 000		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interviews, resident interviews, observations, record reviews, and facility policy and procedure reviews, the facility failed to provide supervision to prevent the elopement of a delusional resident who voiced and was identified	F 689	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	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 689	Continued From page 3	F 689		

by the facility as being at high risk for elopement. Resident #1 was one (1) of six (6) Residents that the facility had identified as at risk for elopement. (Resident #1)

The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) Past Non-Compliance (PNC) which began on 05/25/24, when the facility allowed Resident #1 to leave the facility through his disassembled bedroom window unsupervised and unwitnessed. Resident #1 was found several miles away by local Law Enforcement at a store. He was assumed by the facility to be away from his bedroom for approximately five and a half (5.5) hours. Resident #1 was last seen by Certified Nursing Assistant (CNA #1) on 05/25/24 at approximately 12:30 A.M. and was not seen again until his return to the facility at approximately 6:00 A.M. The facility's failure to provide supervision placed Resident #1 and other residents identified elopement risk placed the residents with likelihood of serious injury, harm, impairment, or death.

On 05/29/24 at 2:00 P.M. the SA informed the facility's Administrator (ADM) of the Immediate Jeopardy (IJ) and provided the IJ Template. The facility provided an acceptable Removal Plan-Past Non-Compliance (PNC) on 05/29/24, in which the facility alleged all corrective actions were completed to remove the IJ (PNC) on 05/28/24, prior to the SA entering the building on 05/29/24.

The (SA) validated the Removal Plan on 5/29/24-05/30/24 and determined the IJ (PNC) was removed on 05/28/24, prior to SA's entering the building on 05/29/24. The Scope and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	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 689	Continued From page 4	F 689		

Severity (S/S) for F689-Accidents/Hazards/Supervision, was lowered from a "K" to an "E" due to the facility being recently cited for the same deficiency on 04/05/24.

Findings Include:

The facility policy and procedure titled "Wander Management, Monitoring System and Resident Elopement Protocol" dated Revised 1/17/18 Reviewed 01/2023 read: "To monitor safety of residents at risk for elopement. To provide a system to alert staff that a resident may be attempting to leave the facility. It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents, so identified, will have these issues addressed in their individual care plans."

Interview on 05/29/24 at 9:50 A.M. with the facility Administrator (ADM) revealed that Resident #1 had made an attempt to leave the facility on 05/19/24 with staff following close behind him which prevented Resident #1 from leaving the front porch of the facility after he voiced that he needed to leave to get a job. On May 19, 2024 Resident #1 had a Brief Mental Status Score (BIMS) of 14 which indicated that he was cognitively intact, but he did voice delusional statements such as he needed to return to his job and/or report for a job interview. Resident #1 had written large documents in a note book that he explained to staff were his resume' documents and that he needed to leave to take his resume' with him to job interviews. The ADM stated that Resident #1 had been admitted to the facility from another nursing home. The ADM stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	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 689	Continued From page 5	F 689		

Resident #1 had a known history of wandering and was an elopement risk. The ADM stated that Resident #1 was identified as one (1) of six (6) residents living in the facility that were wanderers and high risk for elopement. The ADM stated that Resident #1 had been given a wander guard to sound when Resident #1 got close to the exit doors. The ADM stated that the wander guards do not work on the windows, but on 05/25/24 after midnight that Resident #1 left the facility through his disassembled bedroom window and he had taken his wander guard off and left it on his bedroom dresser. The ADM provided pictures made with her cell phone of the disassembled window, a broken and bent window screen, and the window taken completely out of its frame and sitting on top of room air conditioner inside Resident #1's private room. The ADM stated that when Resident #1 eloped undetected and unsupervised from the facility on 05/25/24 after midnight, he took with him a roll of toilet tissue, his note book of writings/resume', an extra pair of black tennis shoes and a black hooded sweat shirt that he had wrapped around his body as a "make-shift" back pack. Resident #1 was wearing a white T-shirt, olive green cargo pants, eye glasses and blue tennis shoes. Resident #1 was last seen by a Certified Nursing Assistant (CNA#1), at 12:30 A.M. on 05/25/24 and at approximately 2:00 A.M. on 05/25/24 LPN #1 discovered that Resident #1 had disassembled his bed room window and had left out his window unsupervised and undetected. The local Law Enforcement contacted the ADM at approximately 5:44 A.M. that Resident #1 was at the Dispatch Office waiting for the facility to come and pick him up. The ADM and the DON drove to the Dispatch office and obtained Resident #1 and brought him back to the facility at approximately 6:00 A.M.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	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 689	Continued From page 6	F 689		

The DON and nursing staff assessed Resident #1 and found him to be delusional but not physically injured. The facility placed Resident #1 on one to one (1:1) close observation with documented visual accountability every 15 minutes. The wander guard was re-placed on Resident #1 and his bedroom window was re-paired and fastened with screws drilled into the frame by the Maintenance Department. Resident #1 has remained on 1:1 since his return to the facility and his 1:1 will remain in place until he is discharge on 5/31/24 to a "locked unit" at another facility.

Interview and observation of Resident #1 on 05/29/24 at 10:15 A.M. revealed Resident #1 made no attempts at conversation. Resident #1 stated that he was "getting in his exercise". Observation of his room revealed that he was in a private room with no roommate, the bedroom window was securely attached and in working order. The window would not open all the way but provided approximately six (6) inches of an opening for fresh air. The screen on the outside of the window was attached. Resident #1 had an over bed table in front of a straight back chair that contained a note book and a pen for writing. The note book appeared to be filled with Resident's personal writings. The ADM demonstrated to surveyor how the window was now securely screwed in to the frame of the window and that it would no longer lift out of the frame. The windows were large and were designed to slide from side to side in order to open. The windows were currently secured as not to slide from side to side but only open approximately six (6) inches. Resident #1 was not present when the ADM demonstrated the current status of his bedroom window. Resident #1 was walking all about the facility with a staff member.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	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 689	Continued From page 7	F 689		

Interview on 05/29/24 at 10:30 A.M. with the Director of Nursing (DON) revealed that she had ridden to the Dispatch Office with the ADM to pick up Resident #1 on 05/25/24 at approximately 6:00 A.M. The DON stated that the weather conditions on 05/25/24 were not good and that it was raining and hot. Upon returning Resident #1 to the facility on 05/25/24 at approximately 6:00 A.M. the DON, along with other nursing staff, LPN #1 and RN Supervisor #2, assessed Resident #1 and all identified wanderers and found no physical injuries and wander guards were in place and functioning properly. The DON stated that she over saw the verification and accountability of all residents per the census of 149 residents. DON stated that Resident #1 had been assessed upon his admission to be at high risk for elopement and a wander guard was put in place. The DON stated that she re-assessed Resident #1 on 05/25/24 and documented his High Risk for Wandering on the "Wander Data Collection form." The DON stated that the Maintenance department had been at the facility on 05/25/24 and had secured the bedroom window of Resident #1's room prior to 7:00 A.M. on 05/25/24. The DON stated that she also re-assessed Resident #1 for his high risk for wandering again on 05/28/24. The DON confirmed that on 05/28/24 the Quality Assurance (QA) committee members met and discussed the events of Resident #1's elopement. The DON stated that all corrections had been completed on 05/25/24-05/28/24. The DON stated that Resident #1 had been on 1:1 close observation with a staff 24/7 since the elopement on 05/25/24 and would remain on 1:1 until his discharge to a "locked unit" at another facility. The DON stated that the "immediate" dangers of the elopement were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	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 689	Continued From page 8	F 689		

corrected on 05/25/24 when Resident #1 was returned safely, placed on 1:1 close observation with a new functioning wander guard system and the window of Resident #1's room secured and repaired by Maintenance. The facility continued with in-servicing of staff and assessing of residents, and the first QA meeting was on 05/28/24. The Psychiatric Nurse Practitioner came to the facility on 05/28/24 and re-assessed Resident #1 and wrote orders to continue the 1:1.

Interview on 05/29/24 at 2:40 P.M. with Certified Nursing Assistant (CNA #1) revealed that she was a new employee to the facility that was hired on 05/17/24. She stated that on the night of Resident #1's elopement she and two (2) other CNA's were working on the unit and two (2) LPN's. CNA #1 stated that there was plenty of staff working on the unit. She stated that Resident #1 was his "normal" self and was not acting like he was going to leave and he had not voiced anything unusual to her. Resident #1 was assigned to her and she had been checking on him throughout the night. CNA #1 saw Resident #1 sleeping in his bed at 12:30 A.M. on 05/25/24 in his private room. Then the LPN #1 went at 2:00 A.M. to check on him and he was gone. The entire staff began to look for Resident #1. CNA #1 stated that Resident #1 had not expressed to her that he wanted to leave the facility. CNA #1 stated that Resident #1 eloped through his bed room window.

Interview on 05/29/24 at 3:28 P.M. with the Licensed Social Worker (LSW) , revealed that she had been the LSW at the facility during Resident #1's admission. LSW stated that Resident #1 had delusions and that he had voiced exit seeking behaviors. Resident #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	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 689	Continued From page 9	F 689		

believed that he needed to get a job and that he must get a job to survey the land and water. The LSW stated that Resident #1 had made an attempt to leave the facility on May 19, 2024 when he left out the front door by pushing the door open as another resident entered from the front porch. There were staff members and the receptionist with him and they eventually were able to talk resident into coming back into the building. The LSW stated that she updated the incidents on Resident #1's care plan and had obtained an evaluation at a "geriatric psychiatric" facility as a result of his exit attempt on 05/19/24. The psychiatric facility came and picked Resident #1 up to transport him to the psychiatric facility and while in transit Resident #1 became combative and the transport van turned around and brought Resident #1 back to the facility on 05/20/24. The LSW provided the care plan documentation outlining the events of 05/19/24 and 05/20/24. The LSW verified that the facility staff had been attending in-services since the elopement attempt on 05/25/24. The LSW stated that Resident #1 is active and strong bodied and walks several miles per day throughout the facility for exercise and he continues to believe he has a job. The LSW stated that Resident #1 had a diagnosis of "frontal lobe traumatic brain injury" and that he does not have the ability to reason and he does have a delusional thought process. The LSW stated that Resident #1 would better benefit on a "locked unit" with memory care. The LSW stated that the psychiatric facilities would not consent to admit Resident #1 because he would not give his consent for treatment. The LSW stated that Resident #1's family do not want Resident #1 to be discharged and the family does not come to visit the facility often but they do call Resident #1 and he does talk to family on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	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 689	Continued From page 10	F 689		

telephone. The LSW stated that the family was in agreement with his discharge to a "locked unit with memory care." The LSW stated that Resident #1 will remain on 1:1 until his anticipated discharge on 05/31/24. LSW stated that she updated the wandering information and high risk for elopement residents list and made sure that the books with their information were all updated and current as well as accessible to all staff.

Interview and observation on 05/29/24 at 4:00 P.M. with Resident #1, revealed that he was sitting in his private room with his feet up in a reclining chair watching television. Resident was dressed in olive green cargo pants with black tennis shoes and a black t-shirt. Sitting across from Resident #1 in a chair with an over bed table was a Certified Nursing Assistant (CNA) charting on the resident every thirty (30) minutes. Resident #1 stated to surveyor that he was watching a preacher on the TV but was unable to recall what the preacher's name was or what the sermon was about. Resident's speech was pressured and rapid and he was talking about his resume' and his job interviews that he had arranged. Resident's thoughts were loose and his sentences were disconnected. He rapidly changed from subject to subject and his thought process was disconnected from his answers. The writings were not comprehendible. On 05/29/24 at 4:00 P.M. Resident #1 told surveyor that he needed to leave in order to get to work. Resident #1 presented as ambulatory and agile. Resident had an agenda and he expressed that he was leaving. Resident was unable to recall ever being in an accident. Resident said that his brain had been cut open and taken out and cleaned and sewed back in his head. Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	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 689	Continued From page 11	F 689		

rambled on in a rapid and repetitive manner. Resident was oriented to self, but was not oriented to situation, time, place, or date.

Interview on 05/29/24 at 5:30 P.M. with the evening Receptionist #1, revealed that she worked the front desk and was in charge of the front door exiting and entering. She worked Monday -Friday 5:00 P.M.-7:00 PM and she worked weekends 8:00 A.M. -7:00 P.M. She stated that she was at the front desk on 05/19/24 at approximately 6:00 P.M. when Resident #1 attempted to leave the facility. She stated that she attempted to hold the door shut when Resident #1 pushed her and the door open. Resident #1 got out on the front porch but staff were able to distract him and coax him back in to the building. She stated that Resident #1 walked constantly and that he walked approximately 5-10 miles per day throughout the facility.

Interview on 05/29/24 at 7:07 P.M. with Registered Nurse (RN#1). She stated that she was the supervisor for the night shift at the facility on 05/25/24 when Resident #1 eloped. She stated that there were plenty of staff in the building and that the unit that housed Resident #1 contained three (3) CNA's and two (2) LPN's and one (1) RN supervisor. She stated that she was called to report Resident #1 was missing at approximately 2:00 A.M. on 05/25/24. She stated that she saw the window in his room removed from the frame and the screen broken out and Resident #1 was no where in the facility. The entire staff immediately began searching for Resident #1. RN#1 stated that she was at the facility when Resident #1 was returned on 05/25/24 at approximately 7:00 A.M. RN #1 stated that the weather conditions on 05/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	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 689	Continued From page 12	F 689		

were rainy and hot. RN #1 stated that Resident #1 had a fixed delusion that he was going to leave and go to work. When Resident #1 returned to the facility she assessed him and other residents. RN#1 began in-services with staff on 05/25/24. All residents were accounted for and unharmed.

Interview on 05/30/24 at 8:55 A.M. with Registered Nurse (RN#3) revealed she was responsible for compiling the care plans for all the residents along with the LSW. She stated that she and the LSW revised and updated Resident #1's care plan. She stated that all staff have access to the care plans and that the care plan information was available to the CNA's through the "care giver guide" that the CNA's maintained on each unit. RN#3 confirmed that after the failed elopement attempt of Resident #1 on 05/19/25 the care plan was updated and after his combative episode on the transportation van, the Care Plan of Resident #1 was updated and again after the elopement on 05/25/24 the Care Plan of Resident #1 was updated.

Interview on 05/30/24 at 9:15 A.M. with Maintenance revealed that he was called to the facility on 05/25/24 in the early morning hours and told that Resident #1 had left the facility through the window of his room. He came to the facility at approximately 2:30 A.M. and assisted with the search of Resident #1. The weather was rainy and visibility was poor. The maintenance man was surprised to see the window taken out of the frame and the screen bent back. Maintenance stated that he never would have thought that someone would be able to remove the window from the frame and leave the facility. Maintenance stated that Resident #1 was brought

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	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 689	Continued From page 13	F 689		

back to the facility between 6:00 A.M. and 7:00 A.M. on 05/25/24. Maintenance had placed the window back and screwed the frame into the wall preventing the window to slide out of its track. Resident #1 was placed on 1:1 with staff at his side 24/7.

Interview on 05/30/24 at 9:30 A.M. with Licensed Practical Nurse (LPN #1) revealed that she had worked at the facility for about four (4) years as the night LPN. She stated that Resident #1 would wake up during the night several times and come up to the nursing station asking for snacks to eat. LPN #1 stated that she thought it odd that he had not been up to the desk asking for his snacks so about 2:00 A.M. she took a snack to Resident #1's room and found him gone and the window removed. LPN #1 stated that there were plenty of staff working at the facility on 05/25/24 during the evening shift. LPN #1 called the ADM and DON and the Resident's Representative and the nurse practitioner to report the elopement. LPN #1 stated that CNA #1 had reported seeing Resident #1 in his bed sleeping at approximately 12:30 A.M. and that CNA #1 was the last person to see him. LPN #1 stated that Resident #1 was returned to the facility at approximately 6:30 A.M. on 05/25/24 with the ADM and the DON. The local Sheriff 's office had found Resident #1. It was approximately 5.5 hours that Resident #1 was reported to be missing from the facility. No one saw him leave and no one knew what time it was when he eloped.

Interview and observation on 05/30/24 at 2:30 P.M. with Receptionist #2 of the front desk and front door of the facility revealed that she sits at the front desk monitoring the front door from 8:00 A.M. - 5:00 P.M. Monday through Friday and she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	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 689	Continued From page 14	F 689		

had the high risk for elopements book at the desk with her and she knew the names and faces of all six (6) residents on the list. Receptionist #2 showed surveyor the high risk for elopement binder with all the information on all six (6) wanderers. The wander guard system was tested with a wander guard and it sounded loudly when it reached the front door. Wander guard system intact and working properly. The front door was observed to be locked and the Receptionist #2 was observed to push a button or use a code on a punch pad to open the door to let visitors and residents and staff in and out. No resident was observed to use the punch pad entering a code to release the door. Only staff were observed using the punch pad to enter and exit.

Record review of the "Face Sheet" of Resident #1 revealed that he had an admission date to the facility of 03/27/2024. Resident #1's admitting diagnoses were Traumatic Subdural Hemorrhage without loss of Consciousness; Epilepsy; Frontal Lobe and Executive Function Deficit; Mild Cognitive Impairment; Confusion Arousals; Difficulty Walking; Lack of Coordination; Muscle Weakness; among other diagnoses.

Record review of the Minimum Data Set (MDS) assessment dated 03/27/204 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated he was not cognitively impaired.

Record review of the facility's assessment for "Risk of Elopement" dated 03/27/24, 05/25/24, and 05/28/24 revealed that Resident #1 was assessed as a "High risk for Wandering."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	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 689	Continued From page 15	F 689		

Record review of the psychiatric Nurse Practitioner's assessment of Resident #1 dated 05/28/2024 revealed: "Resident is referred by staff for severe confusion, delusions, and wandering/leaving facility." The note indicated "Multiple redirections required throughout visit but thoughts return to severe delusions ...I cannot recommend that 1:1 observation be discontinued at this time as risk of elopement remains high." Recommendations: Add diagnosis of Vascular Dementia with Psychotic disturbance."

Record review of the care plan for Resident #1 dated 03/29/2024 revealed that he was care planned as at high risk for elopement/wanderer r/t (in reference to) that he wanders aimlessly throughout the facility. Interventions on the care plan documented on 03/29/2024 Resident presented with exit seeking behaviors, Resident continues attempts to elope. Wander evaluation scored as high risk. 05/19/2024 While a resident was entering the building, this resident pushed the receptionist and exited the building. Staff remained with resident the entire time. Resident refused to come back in the door. Resident sat on bench accompanied by nurse after calming down. 05/20/2024 -SW was notified the resident was unable to receive treatment from Freedom behavior due to the resident being combative and transportation having to stop during transport. "Encourage me to participate in activities; Observe for signs of agitation, pacing, repetitive verbalizations of wanting to leave/go home, restlessness."

IJ Removal Plan

On 05/29/2024 at 2:00 P.M. the State Agency (SA) notified the facility Administrator of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	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 689	Continued From page 16	F 689		

Immediate Jeopardy (IJ). State Agency Surveyor provided the facility with the Immediate Jeopardy (IJ) templates. Facility respectfully submits this removal plan.

Brief Summary of Events

On 05/25/2024 at approximately 2:00 A.M. it was discovered that Resident # 1 exited the building through his window by disassembling the window from the frame. Resident #1 had a wander guard on which he removed prior to exiting. The wander guard was properly functioning but does not alarm when removed nor if exiting through a window or other means of egress. The facility failed to provide supervision to prevent the elopement of Resident # 1, who was deemed an elopement risk and left the facility unattended. This failure allowed Resident # 1 to be away from the facility unnoticed and unsupervised on 05/25/2024 from 12:30 A.M. until 5:44 A.M., when the facility was alerted by the Sheriff's department that the resident had been located. This was approximately 5.5 hours after Resident #1 was last observed in the facility by Certified Nursing Assistant (CNA) #1. The facility picked up Resident #1 at the local sheriff dispatch office at 5:51 A.M.

Corrective Actions

1. On 5/25/2024 at 2:00 A.M., LPN (Licensed Practical Nurse) #1 made rounds and Resident #1 was not present in his room and his window was disassembled.
2. On 5/25/2024 at 2:02 A.M., LPN #1 initiated a facility elopement drill. Resident #1 was not located in the facility and all residents were accounted for.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	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 689	Continued From page 17	F 689		

3. On 5/25/2024 at approximately 2:19 A.M., the Administrator was notified by LPN #1 of Resident #1 missing from facility.
4. On 5/25/2024 at approximately 2:24 A.M., the Director of Nurses was notified by the Administrator of Resident #1 missing from the facility.
5. On 5/25/2024 at approximately 2:25 A.M., the local Police Department was notified by RN (Registered Nurse) Supervisor #1 of Resident #1 missing from the facility.
6. On 5/25/2024 at approximately 5:44 A.M., the facility Administrator was notified by the Sheriff Department that Resident #1 had been located.
7. On 5/25/2024 at approximately 5:51 A.M., the Administrator and Director of Nurses picked up Resident #1 at local dispatch office.
8. On 05/25/2024 at approximately 6:00 A.M., the RN (Registered Nurse) Supervisor #1 conducted a head-to-toe body assessment on Resident #1 to review for any skin abnormalities or concerns. Resident #1 had no negative skin issues or concerns.
9. On 05/25/2024 at about 6:00 A.M., the DON oversaw verification of all residents in facility using census. The census in the facility was 149 with 2 residents in the hospital. All 149 residents were accounted for or verified.
10. On 05/25/2024 at approximately 6:15 A.M., Resident #1 was placed on 1:1 monitoring.
11. On 05/25/2024 at approximately 6:15 A.M., the wander guard bracelet was verified to work properly by checking function with door alarm by DON, and then placed on Resident #1's left wrist.
12. On 05/25/2024 at approximately 6:20 A.M., the facility staff was interviewed by the Administrator to determine the timeline of events leading up to Resident #1's exit of facility. Statements were collected.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	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 689	Continued From page 18	F 689		

13. On 05/25/2024 at approximately 6:30 A.M., staff present in the facility during the time of Resident #1 exit, received immediate in-service by the DON and Administrator on the Elopement procedures, Abuse/Neglect, Vulnerable Adult Act and Rounding.
14. On 05/25/2024 at approximately 6:40 A.M., all required state agencies were notified of Resident #1 elopement.
15. On 05/25/2024 at approximately 7:00 A.M., Maintenance assessed Resident # 1's window. Window glass appeared intact and window stopper in place. Maintenance reassembled window and inserted additional safety mechanisms to prevent window from being disassembled in the future by Resident #1.
16. On 05/25/2024 approximately 7:15 A.M., the LPN #1 initiated facility-based incident reporting on Resident #1.
17. On 05/25/2024 at about 7:20 A.M., Maintenance initiated an audit of all 1st floor windows to ensure they are intact and functioning properly. All windows were intact and functioning properly. Maintenance initiated adding additional safety mechanisms to prevent window from being disassemble from frame.
18. On 05/25/2024 at approximately 07:27 A.M., the Nurse Practitioner (NP) was notified by the RN Supervisor #1 of Resident #1 elopement and return to the facility.
19. On 05/25/2024 at approximately 07:27 A.M., Resident #1 Responsible Party was notified by the Administrator that Resident #1 had been returned to the facility.
20. On 05/25/2024 at approximately 08:36 A.M., licensed nurses were notified to perform acute charting on Resident #1 every shift for the next 72 hours to review resident's physical, mental, and psychosocial needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	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 689	Continued From page 19	F 689		

21. On 05/25/2024 at 7:04 P.M., the DON completed a post Elopement incident. Resident #1 remains high risk for Elopement.
22. On 05/27/2024 at approximately 08:21 A.M., the Social Services Director followed up on resident's psychosocial needs and will continue for the next 72 hours.
23. On 05/28/2024 at approximately 12:00 P.M., the Social Services Director reviewed the wander and elopement binders to ensure all are reflective of results.
24. On 05/28/2024 at approximately 12: 43 P.M., Resident #1 was assessed by Psychiatric NP.
25. On 05/28/2024 at approximately 2:00 P.M., a Quality Assurance Committee Meeting was held with the Medical Director, Administrator, Assistant Administrator, Director of Nursing/Infection Preventionist, and the Assistant Director of Nursing to discuss Resident #1 elopement along with plan of correction.
26. On 05/28/2024 at approximately 6:00 P.M., the Assistant Director of Nursing audited current high-risk wander patients to review orders and care plans for accuracy. There are currently six (6) wander patients.
27. On 05/28/2024 at approximately 7:25 P.M., the RN Supervisor #2 performed an elopement drill to review and educate night shift on policies and procedures on elopement.
28. On 05/28/2024 at approximately 11:15 P.M., the RN Supervisor # 1 performed an elopement drill to review and educate evening shift on policies and procedures on elopement.
29. The facility could not anticipate that the resident would dissemble his window and leave the facility. The facility feels like the IJ's were removed on 05/28/2024.

The facility alleged that all activities to remove the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	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 689	Continued From page 20 IJ were completed on 05/28/24 prior to the SA entering the building on 05/29/24. State Agency (SA) Validations were made onsite during the complaint investigation, CI MS #25237. On 05/29/24, the SA validated through interviews and record reviews that all corrective actions had been taken by the facility to remove the IJ and the IJ was removed on 05/28/24 prior to the SA entering the building on 05/29/24.	F 689		