

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2024  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255146</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>11/14/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>YAZOO CITY REHABILITATION AND HEALTHCARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>925 CALHOUN AVENUE</b><br><b>YAZOO CITY, MS 39194</b>                                                                                                                                                                                        |  |                                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                 |  | (X5)<br>COMPLETION<br>DATE                                             |
| F 000                                                                                      | INITIAL COMMENTS<br><br>The State Agency (SA) conducted an annual re-certification survey with three (3) complaint investigations (CI MS # 26597, CI MS #26604, and CI MS# 26962) at the facility from 11/12/14-11/14/24. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA identified non-compliance and cited F689 for CI MS#26962 related to accidents and hazards. There were no deficiencies cited for CI MS # 26597 and CI MS #26604. The SA also cited F550, F558, F565, F578, F584, F656,F677, F757, F761 and F880.                                                                                                                                                                                                        | F 000                                                                      |                                                                                                                                                                                                                                                                                          |  |                                                                        |
| F 689<br>SS=E                                                                              | The census at the time of the survey was 131 and the facility is licensed for 165 beds.<br>Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, record review and facility policy review, the facility failed to monitor frequently and have provided increased supervision to a resident who was identified by the facility as being at high risk for wandering for one (1) of seven (7) residents at risk. (Resident # 73). | F 689                                                                      | 1. On 11/2/2024 at 5:47 P.M., Resident #73 returned to the facility with nursing staff and Responsible Party. It was noted at that time that Resident #1's wander guard was not working. Wander Guard has an active by date of 02/26/2025 with a three-year battery and was purchased on |  | 12/21/24                                                               |

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

TITLE

(X6) DATE

Electronically Signed

11/27/2024

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.

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| F 689                                                                                      | <p>Continued From page 1</p> <p>Findings Include:</p> <p>Record review of the facility policy titled, "Wander Management Monitoring System and Resident Elopement Protocol," with a revision date of 1/17/18 revealed, "Purpose: To monitor safety of residents at risk for elopement" ... Policy: "It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible..."</p> <p>Record review of facility investigation revealed that on 11/2/24 at 5:00 PM, the Administrator (ADM) was contacted by the Director of Nursing (DON) notifying her that Resident #73 had walked out the front door of the facility and was returned to the facility at approximately 5:30 PM. Resident #73 stated to the nurse that some people came in the front door of the facility so he went out the door to go visit his friends. Upon returning the resident inside the facility, it was noted that Resident #73's wander guard bracelet did not alarm. Investigation revealed that the wander guard bracelet appeared to have malfunctioned. Maintenance arrived and tested all the doors in the facility and the wander blue system. Resident #73's wander guard was replaced, and he was placed on one-on-one monitoring. The malfunctioning of the bracelet was noted to be sudden, and the previous checks did not reveal any issues.</p> <p>Record review of elopement assessment dated 8/30/24, revealed a score of 25, indicating Resident #7 was high risk for wandering, but did not indicate that the resident required more frequent monitoring.</p> <p>Licensed Practical Nurse (LPN) #1 was</p> | F 689                                                                      | <p>07/09/2024. On 11/02/2024 at 6:31 P.M., licensed nurses were notified to perform acute charting on Resident #73 daily to review resident's physical, mental, and any psychosocial needs. On 11/02/2024 at 6:45 P.M., Registered Nurse (RN) Supervisor #1 Conducted a head-to-toe assessment on Resident # 73 to review for any skin abnormalities or concerns. Resident # 73 had no negative skin issues or concerns.</p> <p>2. The facility determined that each of the 133 residents has the potential to be affected.</p> <p>3. On 11/02/2024 at 7:15 P.M., the Maintenance Director tested and verified that all wander guard monitoring systems and red door alarms were in good working order. On 11/02/2024 at approximately 7:45 P. M., Assistant Director of Nursing (ADON) initiated education with all staff to include Certified Nursing Assistants, Licensed Nurses, housekeeping staff, business office staff, therapy staff, dietary staff, and administrative staff on Elopement procedures, Abuse/Neglect, MS Vulnerable Adult Act, and Resident's Rights. Beginning 11/18/2024, ADON initiated education with all licensed nursing staff on a new monitoring process located in the electronic Medication Administration Record to include visual</p> |                            |                                                                        |

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| F 689                                                                                      | <p>Continued From page 2</p> <p>interviewed on 11/12/24 at 11:00 AM and stated that she last saw Resident #73 on 11/2/24 around 12:45 PM, during lunch. She stated that Resident #73 walks around the facility, spending time on the first and second floors, often sitting on the couch on the first floor close to the door. LPN #1 reported that earlier in the day, she had checked Resident #73's wander guard by testing it near the front door, where it triggered the alarm, so she knew the wander guard had worked earlier in the day. LPN #1 confirmed that she did not look for the resident again until around 4:15 PM when she needed to check his blood sugar. LPN #1 stated that the facility doesn't have to document on the medical record that they have seen the resident throughout the day other than when it is time for his blood sugar checks at mealtimes or medications to be given.</p> <p>An interview with Certified Nursing Assistant (CNA) #1 on 11/12/24 at 11:15 AM, confirmed that Resident #73 walks around the facility, spending time on the first and second floors and confirmed that she did not attempt to locate the resident before her shift ended at 3:00 PM.</p> <p>An interview on 11/13/24 at 8:30 AM with the Administrator confirmed that staff failing to check on the location of Resident #73, who was at high risk for wandering, from 12:45 PM until 4:15 PM could place him at risk of accidents and/or injury.</p> <p>Record review of the "Admission Record" revealed the facility admitted Resident # 73 on 7/12/2024 with diagnoses that included Cognitive Communication Deficient.</p> <p>Record review of the Minimum Data Set Assessment (MDS) with an Assessment</p> | F 689                                                                      | <p>confirmation of all residents at risk for wandering every hour.</p> <p>4. Beginning the week of 11/18/2024, Assistant Director of Nursing will review two (2) at risk for wandering residents per week for twelve (12) weeks to ensure compliance with new electronic medication administration record monitoring for residents at risk to wander. A report beginning on 12/11/2024 will be submitted to the Quality Assurance Performance Improvement committee monthly for three (3) months for review and recommendations. The Director of Nursing is responsible for monitoring, reporting, and compliance.</p> |                            |                                                                    |

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| F 689                                                                                      | Continued From page 3<br>Reference Date (ARD) of 10/19/24 revealed a<br>Brief Interview of Mental Status score of 9,<br>indicating that Resident #73 has moderate<br>cognitive impairment. | F 689                                                                      |                                                                                                                          |                            |                                                                        |