MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	82CI	A. BUILDING: _____ B. WING _____	C 11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CE	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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual re-certification survey with three (3) complaints, MS CI # 26597, MS CI #26604, and MS CI # 26962 at the facility from 11/12/14-11/14/24. During the survey, the SA determined that the facility was not in compliance with the requirements of the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The SA identified non-compliance and cited M640 for MS CI #26962 related to accidents. There were no deficiencies cited for MS CI # 26597 and MS CI #26604. The SA also cited M500, M610, M705, M1210 and M1570. The census at the time of the survey was 131 and the facility is licensed for 165 beds.	M 000		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level II Pattern 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). Findings Include:	M 640	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 07/09/2024. On 11/02/2024 at 6:31 P.M., licensed nurses were notified to perform acute charting on	12/21/24

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M 640	Continued From page 1 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..." 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. 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. Licensed Practical Nurse (LPN) #1 was 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	M 640	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 #1Conducted a head-to-toe assessment on Resident # 73 to review for any skin abnormalities or concerns. Resident # 73had no negative skin issues or concerns. 2. The facility determined that each of the 133 residents has the potential to be affected. 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 confirmation of all residents at risk for wandering every hour. 4. Beginning the week of 11/18/2024,	

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M 640	Continued From page 2 #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. 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. 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. Record review of the "Admission Record" revealed the facility admitted Resident # 73 on 7/12/2024 with diagnoses that included Cognitive Communication Deficient. Record review of the Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 10/19/24 revealed a Brief Interview of Mental Status score of 9, indicating that Resident #73 has moderate cognitive impairment.	M 640	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.	

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