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 _____	11/14/2024

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 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. The census at the time of the survey was 131 and the facility is licensed for 165 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550		12/21/24

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

Electronically Signed | 11/27/2024

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 _____	11/14/2024

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 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review and facility policy review, the facility failed to provide a resident with a dignified existence as evidenced by leaving a urinary catheter bag uncovered for one (1) of five (5) sampled residents with urinary catheters. Resident #20. Findings Include: Review of the facility policy titled, "Protocol for Keeping Catheter Bags Covered for Dignity Purposes in a Nursing Home" with no revision date revealed under "Objective...To maintain the dignity, privacy, and comfort of residents with catheter bags by ensuring that catheter bags are	F 550	Preparation and submission of the plan of correction by Yazoo City Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirement of state and federal law. 1. On 11/13/2024, Resident # 20□s Catheter bag was immediately changed by Licensed Practical Nurse (LPN) to a bag with a built-in privacy feature. A	

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 _____	11/14/2024

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 550	Continued From page 2 properly covered ... 2. Proper Covering of Catheter Bags...Catheter bags should be covered with an appropriate, discreet cloth or garment". Record review of the facility form, "Resident Rights" that is provided to residents when admitted to the facility, revealed that residents were to be "treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care of his personal needs..." An observation on 11/12/24 at 11:19 AM, revealed Resident #20 sitting up in her wheelchair in her room watching television. There was an uncovered urinary catheter bag hooked on the wheelchair frame and there was amber urine visible. An observation and interview on 11/13/24 at 10:28 AM, with Resident #20 revealed her lying in her bed eating breakfast. There was an uncovered urinary catheter bag hanging on the bed frame with 900 milliliters of urine in the bag and it was visible from the hallway. Resident #20 revealed that it bothered her a little for her urine to be visible and stated, "It makes me feel kinda icky." She revealed that she would like her catheter bag to be covered. Record review of Resident #20's "Order Summary Report" revealed an order effective 10/31/24 for a privacy bag or covering over urine collection bag for dignity. An interview on 11/13/24 at 10:47 AM, with Licensed Practical Nurse (LPN) #4, revealed that they usually had blue privacy urinary bags on all residents with catheters. She confirmed that	F 550	one-on-one education was initiated by the Assistant Director of Nursing (ADON) with Registered Nurse (RN) Supervisor and LPN on checking all admissions to ensure that the resident has the proper privacy bag. 2. The facility determined that each of the 133 residents has the potential to be affected. 3. On 11/15/2024, an audit was completed by ADON on residents having the correct privacy bag. 0 of 5 residents had the incorrect privacy bag. Beginning 11/20/2024, all nursing staff received a directed in service from Nurse Educator on ensuring that all residents have a catheter bag that either has a privacy covering or a blue privacy urinary bag. 4. Beginning the week of 11/18/2024 the RN Supervisor will observe two (2) residents per week for three (3) months to ensure that residents have appropriate privacy covering attached to their catheter bag. 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.	

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 _____	11/14/2024

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 550	Continued From page 3 Resident #20 did not have a privacy catheter bag in use and that she would get it changed out. An interview with Registered Nurse (RN) #2 on 11/13/24 at 10:53 AM, revealed that they used blue privacy urinary catheter bags and that the catheter bag that Resident #20 had must have come from the hospital. She confirmed that Resident #20's catheter bag did not have a privacy covering and that visible urine was a dignity issue. She also agreed that someone should have caught this and changed it. Record review of Resident #20's "Admission Record" revealed an admission date of 09/05/24 and that she had diagnoses that included Malignant Neoplasm of the Uterus and Type 2 Diabetes Mellitus. Record review of Resident #20's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/30/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated that she was cognitively intact.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and facility policy review, the facility failed to ensure a call light device was accessible	F 558	1. On 11/13/2024, RN Supervisor placed the call light within reach clipped to Resident□s #7 linen after	12/21/24

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 _____	11/14/2024

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 558	Continued From page 4 for a dependent resident for one (1) of 32 sampled residents. Resident #7 Findings include: Record review of the facility policy titled, "Resident Call System", with review date of 3/28/23, revealed, "Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation...1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor". During an observation and interview on 11/13/24 at 8:30 AM, Resident #7 stated he used the call light to receive the assistance needed for his care, but his call light was not within reach. An observation revealed the resident was lying in his bed and the call light cord was twisted around the bed frame under the foot of the resident's bed and the call light button was not within the resident's reach. On 11/13/24 at 8:33 AM, an observation and interview with Certified Nursing Assistant (CNA) #4 in Resident #7's room, when asked about the call light, she stated the staff were to ensure the light was within each resident's reach, and this one was not where the resident could reach it. Observed her untangling the cord and laying it at the foot of the bed. Registered Nurse (RN) #2 entered the resident's room and confirmed with CNA #4 that the call light was not accessible for the resident, and it should have been secured within his reach. RN #2 stated this resident was cognitive and used the light to receive the care he needed, and it was necessary for the light to be	F 558	Certified Nursing Assistant (CNA) untangled the light from around the bed. The CNA received a one-on-one education from Assistant Director of Nursing (ADON) on the importance of ensuring that all resident□s call lights is within reach whenever the resident is in their room. 2. The facility determined that each of the 133 residents has the potential to be affected. 3. On 11/15/2024, Assistant Director of Nursing (ADON) conducted an audit of all resident□s call lights to ensure they are in reach and not tangled around anything. Beginning 11/20/2024, all staff have received a directed in service from the Nurse Educator on call lights specifically ensuring they are in reach of the resident while the resident is in their room. 4. Beginning the week of 11/18/2024 the RN Supervisor will observe ten (10) residents per week for three (3) months to ensure that residents have their call lights available and in reach when the resident is in their room. 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.	

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 _____	11/14/2024

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 558	Continued From page 5 within his reach. During an interview on 11/13/24 at 2:00 PM, the Director of Nursing (DON) confirmed that the staff members were to clip the light to the bedding within the resident's reach. She acknowledged this resident was cognitive and was able to use the call light to receive care. She confirmed the facility failed to ensure the call light was accessible for this resident. Record review of Resident #7's "Admission Record" revealed the facility admitted the resident on 8/17/2012 with the most recent admission being 7/11/19. His diagnoses included Type 2 Diabetes Mellitus, Hypertensive Heart Disease with heart failure, Chronic Obstructive Pulmonary Disease, and Repeated Falls. Record review of Resident #7's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/20/24, revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact.	F 558		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff	F 565		12/21/24

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 _____	11/14/2024

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 565	Continued From page 6 person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, record review, and facility policy review, the facility failed to resolve grievances related to missing clothes items for four (4) of six (6) residents in the resident council meeting. Resident #15, Resident #115, Resident #124, and Resident #126. Findings include: Record review of the facility policy titled, "Filing Grievances/Complaints", with a revision date of 6/2024, revealed, "Our facility will assist residents, their representatives (Sponsors), other interested family members, or advocates in filing	F 565	1. By 11/14/2024, Resident # 115, 126, 15, and 124□s clothing had already been found or replaced and grievance was resolved. 2. The facility determined that each of the 133 residents has the potential to be affected. 3. On 11/15/2024, the Nurse Educated Social Services and Activities on the grievance policy and responding to grievances in a timely manner.	

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 _____	11/14/2024

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 565	Continued From page 7 grievances or complaints when such request are made ...3. All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing (if requested), including a rationale for the response..." A record review of the "Resident Council" minutes revealed there were complaints regarding missing clothes for the meeting dates of 5/2/24, 6/4/24, 8/2/24, 9/5/24, and 11/1/24. Interviews with residents during the Resident Council meeting on 11/13/24 at 10:03 AM, revealed Resident #15 (Resident Council President), Resident #115, Resident #124, and Resident #126 had concerns that they were still missing clothes. They unanimously voiced that the discussion of missing clothes had been addressed in almost every Resident Council meeting for months. Resident #15 revealed that he has had some compression socks missing for a long time and they tell him they will replace them, but they never do. Resident #126 stated that when he was admitted he had a jogging suit that is still missing. Resident #115 revealed that the shirt she has on now had gone missing a year ago and she had just received it back. She stated that her daughters gave her some new ankle socks for Mother's Day, but she refuses to wear them because she is afraid they won't return from laundry. An interview with the Activity Director on 11/13/24 at 11:04 AM, confirmed that missing clothes has been going on for a long time and they discuss it in almost every Resident Council meeting. She	F 565	4. Beginning the week of 11/18/2024 the Administrator will monitor all grievances weekly for three (3) months to ensure they are completed within the timeframe listed in the grievance policy. Resident council minutes will be reviewed by the Administrator with in one business day after resident's council. A report will be submitted to the Quality Assurance Performance Improvement on 12/11/2024 for review and recommendations then monthly for three (3) months. The Administrator is responsible for monitoring, reporting, and compliance.	

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 _____	11/14/2024

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 565	Continued From page 8	F 565		

stated that she notifies the Licensed Social Worker (LSW) and laundry when the issue is discussed in the meetings. She revealed that she didn't know what was going on to cause this issue and confirmed that it still had not been resolved.

An interview on 11/14/24 at 8:20 AM, with Housekeeper/Laundry #6 confirmed that they do get complaints of missing clothes. She stated that she thinks the biggest issue is that laundry gets backed up and they don't put their names on their clothes.

In an interview on 11/14/24 at 8:45 AM, the LSW confirmed that the laundry issue with missing clothes had been an ongoing problem.

In an interview on 11/14/24 at 9:23 AM, the Administrator confirmed that missing clothing had been an issue for a while. She admitted that she had been aware of the problem and had worked on some things, but it had not been resolved

Resident #15
A review of the "Admission Record" revealed that the resident was admitted to the facility on 12/22/2020.

Record review of Resident #15's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 9-13-2024 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact.

Resident #115
A review of the "Admission Record" revealed that Resident #15 was admitted to the facility on 06/23/2023.

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 _____	11/14/2024

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 565	Continued From page 9 Record review of Resident #115's MDS with an ARD of 9-24-2024 revealed in Section C a BIMS score of 15, which indicated the resident was cognitively intact. Resident #124 A review of the "Admission Record" revealed that Resident #124 was admitted to the facility on 11/24/2023. Record review of Resident #124's MDS with an ARD of 8-15-2024 revealed in Section C a BIMS score of 15, which indicated the resident was cognitively intact. Resident #126 A review of the "Admission Record" revealed that Resident #126 was admitted to the facility on 05/26/2024. Record review of Resident #126's MDS with an ARD of 10-10-2024 revealed in Section C a BIMS score of 14, which indicated the resident was cognitively intact.	F 565		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		12/21/24

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 _____	11/14/2024

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 578	Continued From page 10 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure a resident's code status was accurate in the physician orders for one (1) of 40 residents reviewed for advanced directives during initial pool. Resident #135 Findings Include:	F 578	1. On 11/13/2024, Resident # 135□s physician order was changed to match Resident #135□s advance directive. 2. The facility determined that each of the 133 residents has the potential to be affected.	

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 _____	11/14/2024

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 578	Continued From page 11 The facility provided a statement on letterhead signed by the Administrator that read, "This facility does not have a policy for discrepancies between advance directive and physician order." Record review of Resident #135's "Consent for Cardiopulmonary Resuscitation (CPR)" dated, 7/23/24 revealed, "Decline CPR: I understand that CPR constitutes an extraordinary measure and SHOULD NOT be performed" was checked and signed by Resident #135's family member. Record review of Resident #135's "Physician Order Detail" revealed an order dated 9/23/24, "CPR (Cardiopulmonary Resuscitation)". An interview with Registered Nurse (RN) #1 on 11/13/24 at 10:58 AM, revealed in case of an emergency event, the staff would check Resident #135's Electronic Medical Record (EMR) under the orders to determine the resident's code status. She confirmed, after looking at the EMR, the resident was a full code and would be resuscitated should something happen. An interview with the Admission's Coordinator on 11/13/24 at 11:30 AM, revealed she went over the advanced directives with Resident #135's family member, which elected for the resident to be a DNR (do not resuscitate). She revealed the physician order, and the advanced directive consent should match for the resident and families wishes to be honored in an emergency event. An interview with Social Services #1 on 11/13/24 at 1:14 PM, revealed if Resident #135's physician order and the advanced directive consent do not match, the resident could be resuscitated when	F 578	3. On 11/15/2024 an audit was completed by the Assistant Director of Nursing (ADON) ensuring that all 133 resident□s physician orders match their advance directive. All physician orders and advance directive matched. On 11/20/2024, the Nurse Educator began in services with Licensed nursing staff, Medical Records, and Social Services on making sure that physician orders and advance directives match. 4. Beginning the week of 11/18/2024, Medical Record will review five (5) residents□ chart per week for three (3) months to ensure that advance directive and physician orders match. A report will be submitted to the Quality Assurance Performance Improvement on 12/11/2024 for review and recommendations then monthly for three (3) months. The Director of Nursing is responsible for monitoring, reporting, and compliance.	

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 _____	11/14/2024

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 578	Continued From page 12 the resident and family did not want that. Record review of the "Admission Record" revealed the facility admitted Resident #135 on 7/23/24 with a medical diagnosis of Cerebral Infarction.	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		12/21/24

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 _____	11/14/2024

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 584	Continued From page 13 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to provide a safe, clean, comfortable, and homelike environment for two (2) of three (3) survey days. Findings include: Record review of the facility policy titled, "Homelike Environment" revised February 2021, revealed under the policy statement, "Residents are provided with a safe, clean, comfortable and homelike environment...." Room 103-P An observation on 11/12/24 at 3:23 PM of Room 103-P revealed the smell of urine when standing at the bedside. An observation on 11/13/24 at 1:29 PM in Room 103-P revealed areas of a dark brown liquid scattered around the lid of the commode and multiple large areas of dark brown liquid scattered across the bathroom floor and on the resident's recliner. An observation on 11/13/24 at 2:02 PM in Room	F 584	1. On 11/12/2024, resident□s room 129 was deep cleaned by housekeeping and followed up by the Housekeeping Manager to ensure that room was cleaned. On 11/13/2024, resident□s rooms103, 131, 327 were deep cleaned by housekeeping and followed up by the housekeeping manager to ensure that room was cleaned. On 11/13/2024 Maintenance Assistant replaced the tiles on the 200 hall. On 11/14/2024, the Housekeeping Manager educated the housekeeper on ensuring proper cleaning of resident□s rooms. 2. The facility determined that each of the 133 residents has the potential to be affected. 3. On 11/14/2024, the Housekeeping Manager conducted an in service with all housekeeping staff on the 5 and 7 step method of cleaning all residents□ rooms and restrooms. 4. Beginning the week of 11/18/2024, 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 _____	11/14/2024

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 584	Continued From page 14 103-P revealed had a dried dark brown substance smeared on the bathroom floor that appeared to have been attempted to be cleaned. This observation revealed the scattered dried dark brown substance remaining on the commode and recliner. An interview with Housekeeper #6 on 11/13/24 at 2:04 PM, revealed that they clean the rooms twice a day and sometimes three times. She stated that she had already been in this room twice today cleaning. She confirmed that she observed the dark brown substance that she thought was diarrhea in the room earlier. She stated, "But we aren't supposed to clean that up" and that the Certified Nursing Assistants (CNA) do it with housekeeping sanitizing afterwards. The housekeeper confirmed that she had already mopped the room earlier today, but she didn't mop the bathroom. An interview on 11/13/24 at 2:06 PM, with CNA #3 confirmed that the diarrhea was scattered across the bathroom floor in Room 103-P. She stated that she had attempted to clean it up from the floor, commode and recliner but that she didn't have any cleaner. She revealed that the housekeepers tell us that we have got to clean up bowel movement. An interview on 11/13/24 at 2:15 PM, with Housekeeping #1 stated that it is our policy to let the CNAs clean it up and we just go behind them and sanitize. An interview on 11/13/24 at 2:18 PM, with Housekeeping #4 and Housekeeping #1, Housekeeping #4 stated that "We don't clean up bodily fluids because we don't know what the	F 584	Housekeeping Manager will audit eight (8) resident□s room weekly for the next three (3) months for cleanliness. A report will be submitted to the Quality Assurance Performance Improvement on 12/11/2024 for review and recommendations then monthly for three (3) months. the Housekeeping Manager is responsible for monitoring, reporting, and compliance.	

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 _____	11/14/2024

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 584	Continued From page 15	F 584		

resident might have, aids, hepatitis. We haven't been trained on how to do that, we let the aids do it." Housekeeping #1 confirmed that it is not a homelike environment to allow bowel movement to stay on the floor so long that it dries.

An interview on 11/14/24 at 9:10 AM, with the Director of Nurses (DON) confirmed that her CNA's don't have chemicals to clean up bowel movement in a resident's bathroom. She stated that if they are in the room changing a resident then they are expected to clean up incontinent briefs and take out the trash, but we don't have them cleaning the resident's bathrooms up when a resident messes it up.

Room 129
During an initial tour on 11/12/24 at 10:10 AM, an observation in Room 129 revealed a large dried brown substance smeared approximately 6 inches by 6 inches on the base of the front of the toilet bowl.

During an interview and observation on 11/12/24 at 11:30 AM, CNA #2 confirmed that the front of the toilet bowl had a large area of dried feces, and it looked like it had been there for a while. CNA #2 revealed that housekeeping had just finished cleaning Room 129, but housekeeping does not clean any stool up; rather, the CNAs are responsible for cleaning it.

Room 131

An observation on 11/12/24 at 10:20 AM and again at 2:25 PM in Room 131 revealed a dark brown substance on the floor under the head of the bed. The privacy curtain was hanging off approximately (approx.) eight (8) hooks 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 _____	11/14/2024

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 584	Continued From page 16	F 584		

drooped resulting in it touching the floor on the left side. An observation of room 131's exterior door frame revealed a thick black substance around the frame and side of the wall.

An observation on 11/13/24 at 8:49 AM revealed the condition of Room 131 remained the same as the prior day's observation.

During an interview and observation on 11/13/24 at 1:30 PM, Housekeeper #5 confirmed that Room 131 had a large dark brown substance behind the head of the bed, He stated that it was dirty and possibly from the floor waxing. He confirmed the privacy curtain was off some of the hooks and touching the floor on the left side and that there was a black substance around the bottom door frame of the exterior door and wall. He revealed the floors need good buffing and the room needs to be cleaned.

Room 327-W

An observation on 11/12/24 at 10:43 AM in Room 327-W revealed an air conditioner unit to the right side of the bed with multiple areas of a black substance on the upper front surface of the air flow vents and on the temperature control panel.

An observation on 11/13/24 at 10:32 AM and at 11:30 AM in Room 327-W, revealed an air conditioner unit with black substance on the surface of the air flow vents across the upper front of the unit and control panel.

An observation and interview with Registered Nurse (RN) Supervisor on 11/13/24 at 11:35 AM, confirmed the black substance on the front covering of the air conditioner unit and he

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 _____	11/14/2024

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 584	Continued From page 17	F 584		

revealed that it looked like black dirt. He revealed that it should have been cleaned by housekeeping to maintain a clean environment. He revealed that the black substance in the air vent could be "breathed in" and could cause a respiratory infection.

An interview with Housekeeper #1 on 11/13/24 at 11:38 AM, revealed that they deep cleaned two resident rooms a day and that each resident room was deep cleaned once a month. She confirmed the black substance on the air conditioner unit and stated, "It looks like black lent." She revealed that deep cleaning included bed rails, furniture, and the outer surface of the air conditioner including the air flow vents. She revealed that she didn't know when this room was last deep-cleaned and confirmed that this should have been noticed and cleaned.

An interview on 11/13/24 at 2:27 PM, with Housekeeping #4 confirmed that resident rooms were deep cleaned once a month, and this included the surface of the air conditioner units.

An observation at the end of the 200 hall by the exit door, on 11/12/24 at 12:04 PM revealed a large brown discolored area on the ceiling tiles that measured approximately 2-foot x 1 foot.

An observation and interview with Housekeeping Supervisor #1 on 11/13/24 at 11:20 AM, confirmed the area on the ceiling and described the area as, "looks like something is leaking up there."

An observation and interview with Maintenance #2 on 11/13/24 at 11:26 AM revealed, the discolored area on the ceiling tile was from the air

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 _____	11/14/2024

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 584	Continued From page 18 conditioning unit, which was stored above the ceiling, being stopped up and leaking. He revealed he was not aware that it had leaked onto the ceiling tiles. He confirmed the residents and visitors would expect the building to be in good repair and a homelike environment.	F 584		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		12/21/24

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 _____	11/14/2024

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 656	Continued From page 19 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review the facility failed to implement a care plan related to implementing Enhanced Barrier Precautions (EBP) (Resident #20) and performing activities of daily living (ADL) (Resident's #38 and #80) for three (3) of 30 resident care plans reviewed. Findings include: Review of facility policy titled "Care Plans, Comprehensive Person-Centered," reviewed January 2023, revealed, "Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident..." Resident #20 Record review of Resident #20's "Care Plan"	F 656	1. On 11/13/2024, Resident #38 and Resident # 80□s nails were cleaned and trimmed and Resident #38□s face was cleaned of facial hair by Certified Nursing Assistant and verified by Registered Nurse Supervisor in accordance to the resident□s care plan. On 11/13/2024, the Assistant Director of Nursing (ADON) educated the Licensed Practical Nurse (LPN) on proper personal protective equipment that is needed to be worn while entering a room with enhanced barrier precautions. 2. The facility determined that each of the 133 residents has the potential to be affected. 3. On 11/21/2024 the Nurse Educator began in services with all certified and licensed nursing staff on how to read and understand the Point Click	

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 _____	11/14/2024

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 656	Continued From page 20 revealed that she had a deep tissue injury to the left heel and revealed, "This resident is on Enhanced Barrier Precautions" and "Use EBP when....providing wound care..." On 11/13/24 at 11:20 AM. observation and interview revealed Resident #20 had an EBP sign on their room door. Observed Licensed Practical Nurse (LPN) #4 complete wound care to Resident #20's left heel without donning a gown prior to the wound care being performed. LPN #4 revealed that she knew she was suppose to use EBP with wound care but she got nervous and forgot. She revealed that the purpose of EBP was to prevent the spread of infection, and it was to protect the residents as well as the staff. On 11/13/24 at 11:43 AM An interview with Registered Nurse (RN) #2, confirmed that Resident #20 was on EBP because she had a urinary catheter and a wound. She revealed that EBP was supposed to be followed to protect the residents from the possible spread of infection. Record review of Resident #20's "Admission Record" revealed an admission date of 09/05/24 and that she had diagnoses that included Malignant Neoplasm of Uterus, Pressure - Induced Deep Tissue Damage of Left Heel, and Type 2 Diabetes Mellitus. Record review of Resident #20's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/30/24 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 14 which indicated that she was cognitively intact. Resident #38	F 656	Care Kardex which shows the electronic care plan chart which gives an abbreviated plan of care. 4. Beginning the week of 11/18/2024, Registered Nurse Supervisors will observe five (5) residents per week for three (3) months to ensure that shaving and nail care are being performed in accordance with orders, care plan, and Kardex in Point of Care on Point Click Care. Beginning the week of 11/18/2024, the RN Supervisors will begin observing five (5) staff members per week for three (3) months using proper protective equipment with residents under enhanced barrier precautions. A report will be submitted to the Quality Assurance Performance Improvement on 12/11/2024 for review and recommendations then monthly for three (3) months. The Assistant Director of Nursing is responsible for monitoring, reporting, and compliance.	

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 _____	11/14/2024

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 656	Continued From page 21	F 656		

Record review of Resident #38's care plan, date initiated 9/24/19 revealed, "The resident has an ADL self-care performance deficit". Interventions included "Personal hygiene: shave facial hair as requested by resident or RP (Responsible Party) as needed" and "Bathing/showering: check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Shave as needed".

During an observation and interview on 11/12/24 at 12:15 PM, it was noted that Resident #38 had long, jagged nails with a brown substance noted under her nails and some facial hair. Resident #38 stated the staff would trim and clean her nails and shave her at times, but it had not been done lately.

During an interview and observation with Resident #38 and the Director of Nursing (DON) on 11/13/24 at 2:20 PM, confirmed the resident needed nail care and shaved. She confirmed the facility failed to ensure the ADLs for a dependent resident was done as desired by the resident, therefore, the care plan for ADL care for this resident was not followed.

During an interview on 11/13/24 at 3:40 PM, the Minimum Data Set (MDS) Director stated the care plan provided a guide for the residents' care and Resident #38 had a care plan developed for her ADL care. She confirmed the care plan related to nail care and shaving for this resident was not implemented.

Record review of Resident #38's "Admission Record" revealed the facility admitted the Resident #38 on 9/24/19 with medical diagnoses

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 _____	11/14/2024

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 656	Continued From page 22	F 656		

that included Epilepsy and Intellectual Disabilities.

Record review of Resident #38's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/12/24, revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment.

Resident #80

Record review of Resident #80' s care plan titled, "The resident has an ADL self-care performance deficit r/t (related to) left side hemiparesis, Impaired balance," revealed, interventions: "Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse..."

An interview and observation with Resident #80 on 11/13/24 at 11:00 AM, revealed the residents' fingernails to be approximately three-fourths (3/4) inch long, jagged in appearance, with a thick dark brown substance under all the nail beds. He stated he could not remember the last time his nails were cut.

In an interview with Licensed Practical Nurse #2 on 11/13/24 at 10:25 AM, she confirmed Resident #80's fingernails were very long, jagged and had some type of brown substance under the nails.

An interview with the MDS Coordinator on 11/13/24 at 10:53 AM, revealed after review of Resident #80's ADL care plan that staff did not implement his care plan intervention related to nail care. She then revealed the purpose of the comprehensive care plan is to direct the resident specific care needed for each 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 _____	11/14/2024

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 656	Continued From page 23 Review of the "Admission Record" revealed Resident #80 was admitted by the facility on 7/12/19 with medical diagnoses that included Quadriplegia and Need for Assistance with personal hygiene. Record review of Resident #80's Section C of the MDS with an ARD of 8/15/24 revealed a BIMS score of 15, indicating the resident was cognitively intact.	F 656		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to provide the necessary services to maintain grooming and personal hygiene for residents who are unable to self-perform activities of daily living (ADL's) for (2) two of 161 residents observed for ADL's. (Resident # 38 and #80) Findings include: Review of the facility policy titled, "Activities of Daily Living (ADL), Supporting," revised March 2018 revealed, "Policy Statement:.. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain grooming and personal hygiene..."	F 677	1. On 11/13/2024, Resident #38 and Resident # 80□s nails were cleaned and trimmed and Resident #38□s face was cleaned of facial hair by Certified Nursing Assistant and verified by Registered Nurse Supervisor. 2. The facility determined that each of the 133 residents has the potential to be affected. 3. All nursing staff received a directed in service from the Nurse Educator beginning 11/20/2024 on providing nail care and shaving all residents who need to have that activity of daily living performed in according to care plan and	12/21/24

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 _____	11/14/2024

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 677	Continued From page 24 Resident #38 On 11/12/24 at 12:15 PM, an observation and interview revealed that Resident #38 had long, jagged nails with a brown substance under each of her nails and facial hair. Resident #38 stated the staff sometimes trim and clean her nails and shave her at times, but it's been a while. An observation and interview with Resident #38 on 11/13/24 at 2:10 PM, revealed the resident continued to have long, jagged, dirty nails and facial hair. She stated she wanted her nails to be trimmed and to be shaved and she had told some of the staff, but it had not been done. On 11/13/24 at 2:20 PM, during an interview and observation with Resident #38 and the Director of Nursing (DON) , the DON asked the resident about her nails and facial hair and the resident stated she told the staff she wanted to be shaved and have her nails trimmed, but it had not been done. The DON stated it was the responsibility of the staff to ensure nails were trimmed and clean and that the residents were shaven as they preferred since each resident needed to be cared for and happy with their appearance. She also stated the jagged nails could cause harm to the skin. She confirmed the facility failed to ensure the activities of daily living (ADL) care for a dependent resident was done as desired by the resident. Record review of Resident #38's "Admission Record" revealed the facility admitted the resident on 9/24/19 and diagnoses that included Epilepsy and Intellectual Disabilities.	F 677	documentation of care to include any refusals. Observations were conducted by Registered Nurse Supervisors on 11/15/2024 inspecting all residents for proper nail care and shaving practices. 4. Beginning the week of 11/18/2024, Registered Nurse Supervisors will observe five (5) residents per week for three (3) months to ensure that shaving and nail care are being performed in accordance with orders, care plan, and Kardex in Point of Care on Point Click Care. A report will be submitted to the Quality Assurance Performance Improvement on 12/11/2024 for review and recommendations then monthly for three (3) months. The Assistant Director of Nursing is responsible for monitoring, reporting, and compliance.	

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 _____	11/14/2024

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 677	Continued From page 25	F 677		

Record review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/12/24, revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had a moderate cognitive impairment. Resident #80

On 11/12/24 at 11:00 AM, an interview and observation of Resident #80 revealed the residents' fingernails to be approximately three-fourths (3/4) inch long past the tips of the fingers, jagged in appearance, with a thick dark brown substance under all the nail beds. He stated he could not remember the last time his nails were cut. He then stated he would like to have them cut and cleaned. He stated he has asked staff several times to trim his nails, but it has not been done.

An observation of Resident #80's fingernails on 11/13/24 at 10:15 AM, revealed no change in the resident's fingernails.

On 11/13/24 at 10:25 AM, an interview with Licensed Practical Nurse #2 she confirmed Resident #80's fingernails were very long, jagged and had some type of brown substance under the nails. She revealed that one of the concerns from the nails not being cleaned and trimmed was that he could scratch himself.

On 11/13/24 at 11:00 AM, an interview with the Infection Control Nurse , she confirmed that with Resident #80's nails being long and dirty then the resident could scratch himself and possibly get a skin infection.

In an interview with the Director of Nursing 11/13/24 at 2:36 PM, she revealed Resident #80

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 _____	11/14/2024

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 677	Continued From page 26 stated he wanted his nails trimmed and cleaned today. Record review of the Task Care Guide for November 2024 for Resident #80 revealed no documentation of refusals of care. Review of the "Admission Record" revealed Resident #80 was admitted by the facility on 7/12/19 with diagnoses of Quadriplegia and Need for Assistance with personal hygiene. Record review of Resident #80's Section C of the MDS with an ARD of 8/15/24 revealed in Section C a BIMS score of 15, indicating the resident was cognitively intact.	F 677		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 757		12/21/24

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 _____	11/14/2024

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 757	Continued From page 27 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to monitor a resident receiving anticoagulant medication for signs of bruising and bleeding for one (1) of five (5) residents reviewed for unnecessary medication. Resident #47 Findings include: Record review of the facility policy titled "Anticoagulation-Clinical Protocol" with a revision date of November 2018 revealed under, "Monitor and Follow-Up: 5 ... The staff and physician will monitor for possible complications in individuals who are being anticoagulated and will manage related problems..." Record review of Resident #47's "Order Summary Report" revealed an order dated 9/23/2024, Apixaban oral tablet 2.5 mg (milligrams) Give 1 tablet by mouth two times a day related Peripheral Vascular Disease. Record review of the "Order Summary Report" and the "Medication Administration Record" (MAR) for Resident #47 revealed there was not a monitoring tool for staff to monitor for signs of bruising and bleeding with the anticoagulant (blood thinner) medication Apixaban. An interview with Licensed Practical Nurse (LPN) #5 on 11/14/24 at 8:10 AM, confirmed that Resident #47 is on an anticoagulant medication. She confirmed the facility did not have a	F 757	1. On 11/14/2024, the LPN updated Resident # 47□s orders to include monitoring for bruising and signs of bleeding due to Resident #47 being on an anticoagulant. 2. The facility determined that each of the 133 residents has the potential to be affected. 3. On 11/15/2024, Staff Development Coordinator conducted an audit of all residents on anticoagulants to ensure that monitoring is in place on medication administration record for bruising and signs of bleeding. On 11/20/2024, the Nurse Educator began in services with all licensed nurse on ensuring that an order for monitoring for bruising and signs of bleeding is on all residents who have an anticoagulant ordered. 4. Beginning the week of 11/18/2024 the RN Supervisor will review three (3) residents per week for the next three (3) months on anticoagulants to ensure that there are orders for monitoring for bruising and signs of bleeding. A report will be submitted to the Quality Assurance Performance Improvement on 12/11/2024 for review and recommendations then	

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 _____	11/14/2024

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 757	Continued From page 28 monitoring task implemented on the resident's MAR for bruising or signs of bleeding. She revealed that it is very important to monitor a resident that is on a blood thinner. In an interview on 11/14/24 at 9:05 AM, the Director of Nurses (DON) confirmed that Resident #47 is on an anticoagulation medication, and he should be monitored for bruising or signs of bleeding. She confirmed the resident was not being adequately monitored for the potential outcomes associated with the use of anticoagulation medications, and he should be. Record review of the "Admission Record" revealed Resident #47 was admitted to the facility on 9/23/2024 with medical diagnoses that included Peripheral Vascular Disease.	F 757	monthly for three (3) months. The Assistant Director of Nursing is responsible for monitoring, reporting, and compliance.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		12/21/24

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 _____	11/14/2024

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 761	Continued From page 29 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility policy review the facility failed to ensure the proper storage of drugs as evidenced by a medication cart being left unlocked during medication administration for one (1) of four (4) medication carts observed. Findings Include: Record review of the facility policy titled "Storage of Medications" with reviewed date of July 2024 revealed under policy statement, "The facility stores all drugs and biologicals in a safe, secure, and orderly manner...9. Unlocked medication carts are not left unattended...." An observation on 11/13/24 at 8:20 AM, revealed Licensed Practical Nurse (LPN) #3, administer medications to a resident in room #306. LPN #3 left the medication cart outside of Room #306 with the medication drawers facing the outside of the door. At 8:35 AM, upon exiting Room #306, an observation revealed that the medication cart was unlocked while unattended. There was a resident sitting beside the cart in a wheelchair and two residents who self propelled themselves by the cart during this timeframe. LPN #3 confirmed that the medication cart was unlocked and revealed that residents could have come up	F 761	1. On 11/13/2024, the Licensed Practical Nurse (LPN) immediately locked the cart. On 11/13/2024 the Assistant Director of Nursing (ADON) conducted a one-on-one education with the LPN on always securing the medication cart when cart is unattended. 2. The facility determined that each of the 133 residents has the potential to be affected. 3. On11/20/2024, the Nurse Educator began in services with all licensed nursing staff on securing the medication cart while the medication cart is unattended. 4. Beginning the week of 11/18/2024 the Assistant Director of Nursing will check three (3) nurse□s carts at random times weekly for three (3) months to ensure the cart is properly secured. 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	

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 _____	11/14/2024

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 761	Continued From page 30 to the medication cart and took what they wanted out of the drawers. She confirmed that the medication cart was supposed to be locked at all times unless the nurse was present and preparing medications for administration. An interview on 11/13/24 at 2:36 PM, with Registered Nurse (RN) #2, revealed that the medication carts were supposed to be locked at all times to prevent anyone from getting into the carts while unattended. She revealed that the only time the medication cart should be unlocked was if the nurse was standing at the cart getting medications out. RN #2 confirmed that LPN #3 should have locked the medication cart prior to entering Room #306.	F 761	recommendations. The Director of Nursing is responsible for monitoring, reporting, and compliance.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		12/21/24

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 _____	11/14/2024

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 880	Continued From page 31	F 880		

arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, 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 _____	11/14/2024

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 880	Continued From page 32 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review, and facility policy review the facility failed to ensure that Enhanced Barrier Precautions (EBP) was implemented for a resident that required EBP for (1) of five (5) direct care areas observed. Findings Include: Record review of the facility policy, "Enhanced Barrier Precautions" (EBP) dated 04/01/24 revealed that "EBP are indicated for residents with any of the following:..Wounds and/or indwelling medical devices even if the resident is not known to be infected..." The policy also revealed that gloves and gowns are to be donned when performing wound care. An observation on 11/13/24 at 11:20 AM, revealed Licensed Practical Nurse (LPN) #4, completed wound care to Resident #20's left heel without donning a gown prior to the wound care being performed. LPN #4 revealed that she knew to use EBP with wound care, but she got nervous and forgot. She revealed that the purpose of EBP was to prevent the spread of infection, and it was to protect the residents as well as the staff. There was EBP signage on the resident's door. An interview on 11/13/24 at 11:43 AM, with Registered Nurse (RN) #2, revealed that	F 880	1. On 11/13/2024, the Assistant Director of Nursing (ADON) educated the Licensed Practical Nurse (LPN) on proper personal protective equipment that is needed to be worn while entering a room with enhanced barrier precautions. 2. The facility determined that each of the 133 residents has the potential to be affected. 3. On 11/20/2024, the Nurse Educator began in services with all staff on proper personal protective equipment to use and when proper protective equipment is needed while interacting with residents under enhanced barrier precautions. 4. Beginning the week of 11/18/2024, the RN Supervisors will begin observing five (5) staff members per week for three (3) months using proper protective equipment with residents under enhanced barrier precautions. A report will be submitted to the Quality Assurance Performance Improvement on 12/11/2024 for review and recommendations then monthly for three (3) months. The Infection Preventionist is	

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 _____	11/14/2024

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 880	Continued From page 33 Resident #20 was on EBP because she had a urinary catheter and a wound. She revealed that EBP was supposed to be followed to protect the residents from the possible spread of germs or infection. RN #2 confirmed that LPN #4 should have worn gloves and a gown when she provided wound care for Resident #20. Record review of Resident #20's "Order Summary Report" dated 11/08/24 revealed an order to cleanse the deep tissue injury to her left heel with povidone-iodine and leave open to air. Record review of Resident #20's "Care Plan" revealed that she had a deep tissue injury to the left heel and revealed, "This resident is on Enhanced Barrier Precautions" and "Use EBP when....providing wound Record review of Resident #20's "Admission Record" revealed an admission date of 09/05/24 and that she had diagnoses that included Malignant Neoplasm of Uterus, Pressure - Induced Deep Tissue Damage of Left Heel, and Type 2 Diabetes Mellitus. Record review of Resident #20's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/30/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated that she was cognitively intact.	F 880	responsible for monitoring, reporting, and compliance.	