STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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	F 000		

Initial Comments:

CI MS #17949-Substantiated

On August 10, 2021-August 14, 2021, the State Agency (SA) conducted an onsite complaint investigation, CI MS #17949, for an alleged unreported facility fire that was started by a resident with a cigarette lighter. The SA substantiated the complaint, CI MS #17949, and cited deficiencies SA determined that the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The five (5) deficiencies cited were F609; F610; F656; F689; and F742.

The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 07/26/2021, regarding the facility's noncompliance for not reporting and thoroughly investigating accidents/hazards of a facility fire set by Resident #1 on 07/26/2021. The facility failed to supervise and thoroughly assess Resident #1 to avoid the potential for danger to Resident #1 and to the other facility residents and staff. Resident #1 started a facility fire on 07/26/2021 at approximately 1:30 AM when he set his bed linen on fire with a cigarette lighter and threw it out into the hallway of the facility which activated the facility fire alarm and summoned/deployed the fire department to the facility. Immediately following the fire on 07/26/2021 at approximately 1:30 AM, the facility failed to thoroughly investigate the fire, and failed to report the fire as required per Federal and State regulations. The facility failed to develop the comprehensive plan of care for Resident #1

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

Electronically Signed | 09/13/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1	F 000		

after he ignited his bed linen with a cigarette lighter causing a facility fire of 07/26/2021. The facility failed to thoroughly assess Resident #1's mental and behavioral health in order to address his psychosocial well-being. The facility failed to obtain the appropriate mental health and behavioral health services to address Resident #1's psychosocial well-being after the fire occurred on 07/26/2021. The facility's failure to adequately supervise Resident #1 resulted in his setting his bed linen on fire with a cigarette lighter and throwing it out in to the hallway of the facility which placed this resident and other residents who reside in the facility in a situation that was likely to cause serious harm, injury, impairment or death.

On 08/10/2021 at 4:02 PM, the State Agency (SA) notified the facility Administrator of the IJ and SQC and the facility was presented with the IJ templates for F609 and F689. On 08/11/2021 at 4:20 PM the facility was notified verbally of three (3) additional IJ's and at 5:30 PM on 08/11/2021 the SA presented the facility Administrator with IJ templates for F610; F656; and F742.

The IJ and SQC existed at:
42 CFR(s): 483.12(c)(4) Reporting (F609) Scope and Severity=J
42 CFR(s): 483.12(c)(2) Investigate/Prevent/Correct Alledged Violations (F610) Scope and Severity=J
42 CFR(s): 483.25(d) Accidents/Hazards/Supervision (F689) Scope and Severity=L
42 CFR(s): 483.40(b)(1) Treatment and Services for Mental/Psychosocial Concerns (F742) Scope and Severity=J

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 2 IJ existed at: 42 CFR(s): 483.21(b) Develop/Implement Comprehensive Care Plan (F656) Scope and Severity=J The facility submitted an acceptable Removal Plan on 08/12/2021 at 2:29 PM, in which the facility alleged all corrective actions to remove the IJ's were completed on 08/11/2021 and the IJ's were removed on 08/12/2021. The State Agency (SA) validated the Removal Plan on 08/14/2021 and determined the IJ's were removed on 08/12/2021, prior to exit. Therefore, the Scope and Severity for 42 CFR(s): 483.12(c)(4) Reporting (F609); 42 CFR(s): 483.12(c)(2) Investigate/Prevent/Correct Alleged Violations (F610); 42 CFR(s): 483.21(b) Develop/Implement Comprehensive Care Plan (F656); 42 CFR(s): 483.40(b)(1) Treatment and Services for Mental/Psychosocial Concerns (F742), were lowered from a "J" to a "D," and 42 CFR(s): 483.25(d) Accidents/Hazards/Supervision (F689); was lowered from an "L" to an "F", while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with the regulatory standards. The facility held a license for 180 beds and the census on 08/10/2021 was 121.	F 000		
F 609 SS=J	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		9/13/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 609	Continued From page 3 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, resident interview, and policy and procedure review, the facility failed to report a facility fire, that was set by a resident, to the appropriate State Agency(s) for one (1) of seven (7) residents reviewed for accidents/hazards. Resident #1 set his bed linen on fire with a cigarette lighter and threw it out in the hallway of the facility which sounded the fire alarm and deployed the fire department to the facility on 07/26/2021. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care	F 609	1. On 07/26/21 at approximately 1:30 A.M. LPN #2 called 911 while facility alarm was sounding. Sprinkler systems were not activated as fire induced levels did not reach needed levels to activate. On 7/26/21 at approximately 1:33 A.M. Resident #1 was assessed by LPN #1 and found to have no injuries. The facility has no outside legal representative for Resident #1. Resident #1 is his own responsible party. On 7/26/21 at 1:39 A.M. Yazoo City Fire Department arrived on scene. On 7/26/21 at 1:43 A.M. LPN#2	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 609	Continued From page 4 (SQC) that began on 07/26/2021, regarding the facility's noncompliance for not reporting and thoroughly investigating accidents/hazards of a facility fire set by Resident #1 on 07/26/2021. The facility failed to supervise and thoroughly assess Resident #1 to avoid the potential for danger to Resident #1 and to the other facility residents and staff. Resident #1 started a facility fire on 07/26/2021 at approximately 1:30 AM when he set his bed linen on fire with a cigarette lighter and threw it out into the hallway of the facility which activated the facility fire alarm and summoned/deployed the fire department to the facility. Immediately following the fire on 07/26/2021 at approximately 1:30 AM, the facility failed to thoroughly investigate the fire, and failed to report the fire as required per Federal and State regulations. The facility failed to devise/revise the comprehensive plan of care for Resident #1 after he ignited his bed linen with a cigarette lighter causing a facility fire of 07/26/2021. The facility failed to thoroughly assess Resident #1's mental and behavioral health in order to address his psychosocial well-being. The facility failed to obtain the appropriate mental health and behavioral health services to address Resident #1's psychosocial well-being after the fire occurred on 07/26/2021. The facility's failure to adequately supervise Resident #1 resulted in his setting his bed linen on fire with a cigarette lighter and throwing it out in to the hallway of the facility which placed this resident and other residents who reside in the facility in a situation that was likely to cause serious harm, injury, impairment or death. On 08/10/2021 at 4:02 PM, the State Agency (SA) notified the facility Administrator of the IJ and SQC and the facility was presented with the IJ	F 609	contacted Administrator and Director of Nursing via text message. On 7/26/21 at 1:50 A. M. Administrator contacted facility. On 7/26/21 at 1:53 A.M. Yazoo City Fire Department cleared the scene and departed the facility. On 7/26/21 beginning at approximately 8:30 A.M. Director of Nursing, RN Supervisor #1, RN Supervisor #2, Assistant Director of Nursing (ADON), Medical Records, and Activity Director began resident room checks of the entire facility to ensure all lighters were removed. Room checks were completed, and no lighters were found. On 7/26/21 beginning at approximately 10:30 A.M. Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, Licensed Nurses, housekeeping staff, business office staff, therapy staff, dietary staff, and administrative staff on Abuse and Neglect Prohibition Policy and Flammable materials and storage. On 7/28/21 at 12:30 P.M., the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Social Services, Nurse Practitioner, Activity Director Business Office Manager, Wound Care Nurse and Medical Records held Quality Assurance Performance Improvement Committee meeting where the fire was discussed and Resident Safety. 2. All residents have the potential to be affected. 3. On 08/11/2021 Staff Development	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 609	Continued From page 5 templates. The facility submitted an acceptable Removal Plan on 08/12/2021 at 2:29 PM, in which the facility alleged all corrective actions to remove the IJ's were completed on 08/11/2021 and the IJ's were removed on 08/12/2021. The State Agency (SA) validated the Removal Plan on 08/14/2021 and determined the IJ's were removed on 08/12/2021, prior to exit. Therefore, the Scope and Severity for 42 CFR(s): 483.12(c)(4) Reporting (F609); was lowered from a "J" to a "D," while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with the regulatory standards. Findings include: Record review of the "Abuse Prohibition Policy" dated revised 5/28/2021 revealed, "...All new current employees will receive training and reinforcement on all aspects of this abuse prohibition program. This will be done at the time of initial employee orientation, annually, and through ongoing in-service. The training will include, but not be limited to... Recognizing signs of abuse, neglect, exploitation, and misappropriation of resident property, such as physical or psychosocial indicators... Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect and how to respond. These symptoms, include, but are not limited to, the following: i. Aggressive and/or catastrophic reactions of residents; ii. Wandering or elopement -type behaviors; iii. Resistance to care; iv. Outbursts or yelling out; v.	F 609	Coordinator began education with nursing, administrative, housekeeping, dietary, and contract staff to including Abuse and Neglect Policy, reporting requirements and investigations to include unusual occurrences. 4. Beginning on 8/12/2021 Corporate Clinical Specialist will review all reportable investigations completed by facility to ensure reporting requirements met for the next twelve weeks. Any concerns will be immediately addressed by the Administrator or Director of Nursing for further intervention. A report beginning on 8/18/21 will be submitted to the Quality Assurance Performance Improvement committee monthly for three (3) months for review and recommendations. The Administrator is responsible for monitoring 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 _____	C 08/14/2021

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 609	Continued From page 6	F 609		

and Difficulty in adjusting to new routines or staff. Prevention: 4. Facility staff will immediately correct and intervene in reported or identified situations in which abuse/neglect is at risk for occurring. 5. Residents identified as exhibiting abusive behaviors will be reviewed and have their treatment plans modified as appropriate...Investigation: 1. The facility will thoroughly investigate all alleged violations and take appropriate actions...3. The facility will report the results of the investigation to the enforcement agency in accordance with state law, including the state agency and certification agency...5. Investigations will be prompt, comprehensive and responsive to the situation and contain founded conclusions...Procedure for Prevention of Misappropriation of Resident Property: 1. Upon admission, the facility will assist the resident /family to identify and label personal possessions. 2. A personal possessions inventory will be completed and maintained in the resident's medical record. 3. Resident /family will be educated on the importance of reporting any significant items being brought in /removed so that the inventory can be updated."

Interview on 8/10/2021 at 6:54 AM with the Director of Nursing (DON) revealed upon request by the SA of the Accident and Incident (A&I) Report and verification that that the facility had reported the fire to the SA (State Agency) in a timely manner, she stated she had no knowledge of a fire at the facility in July 2021. DON stated that she had been off some in July 2021 and possibly there had been a fire that she was not informed had occurred.

Interview and observation on 08/10/2021 at 7:38 AM, with Resident #1 stated that he was "having

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 609	Continued From page 7	F 609		

one of those bad days." He stated: "I really don't know what happened." He said that he really believed that he was on too much medicine and that being over medicated caused him to set the fire. Res #1 stated that he had a lighter that he had brought to the facility in his bag upon admission. Res #1 stated that he had been admitted to the facility about a month when he set the fire. Res #1 stated that he use to smoke but "I don't smoke anymore" and confirmed that he set the fire with his lighter that he had in his room. Res #1 stated that he felt bad most of the time and was in a lot of pain. Res #1 stated that he really did not know what he set on fire or where he got it from "but I threw it out into the hallway." He stated that the fire department did come to the unit for the fire and that the fire alarm was sounded when he threw the fire out into the hallway. Res #1 stated that he knew now that he was not suppose to have a lighter in his possession. Res #1 stated that the fire had burned the floor tiles in front of his bedroom. He denied any injury from the fire and stated, "I was ok, I did not get hurt." During the interview, he had rapid disconnected speech. At times, when he was talking, he appeared to loose his concentration. At times, during the interview, Res #1 was difficult to understand. He rambled and mumbled in a soft "rapid" low voice. Res #1 stated that he had not visited with a doctor since the fire and had not left the facility. He stated, "I don't know what made me do it. It was one of those bad days. I started hollering 'fire' and the staff came and got it out."

Interviews on 08/10/2021 at 7:57 AM, with the facility Administrator (ADM) and the facility Director of Nursing (DON) revealed that ADM had been at the facility for five (5) years and the DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 609	Continued From page 8	F 609		

had been at the facility for 21 years and had been the DON for six (6) years. DON stated that she had received a text message that there was a possible "paper" fire that the nurse had put out with a blanket. The ADM stated that the facility was not required to report small fires with no injuries and there was no abuse involved. The ADM stated the "small" fire did not cause any damage and was not reported. ADM stated that there had not been an investigation completed because there was nothing to investigate, the nurse had put the fire out prior to the fire department's arrival and it was "very small." ADM stated that the fire department was called but they did not have to do anything because the small fire was out when the fire department got to the facility. The ADM and DON stated that they were not sure of the exact date of the second fire but that it was 2-3 weeks prior to 08/10/2021. The ADM stated: "We will have to look at the text messages in our phones to get the date of the fire." DON and ADM did not give any details or names involved with the "second floor" facility fire. ADM stated that the resident involved in the fire in July 2021 was not a smoker and that he was a new admission and should not have had a lighter.

Interview on 08/10/2021 at 3:15 PM, with the City Fire Chief, revealed that the report was signed by another firemen that had attended to the fire at the facility on 07/26/2021. Fire Chief stated that the fire alarm did sound and the fire department did come to the facility early in the morning just after midnight at approximately 1:39 A.M. on 07/26/2021. The alarm was sounding when they arrived at the facility and the fire had been put out by a nurse on the second floor of the facility. The Fire Chief stated that there were no injuries reported. The fire Chief stated that he would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 609	Continued From page 9	F 609		

provide a copy of the fire department report to the surveyors.

Record review of the City Fire Dept Report confirmed that the 911 call was dispatched through the 911 services. The 911 dispatch report was obtained and reviewed. The report documented the fire alarm dispatched the Fire Department at 1:31 AM and the Fire Department arrived at 1:39 AM The fire was controlled at 1:53 AM and the unit was cleared at 1:53 AM No other details were documented on the fire department report or the 911 dispatch report.

Record review of the 24 hour reports were obtained and there was no fire documented on the 24 hour report for 7/25/2021-7/27/2021. There was no report of Res #1 documented in the 24 hour report. There was no change in condition for Res #1 documented in the 24 hour report.

Interview on 08/10/2021 at 3:51 PM with the ADM and the DON confirmed that they had not investigated the fire set by Res #1 on 07/26/2021 and they had not reported the fire set by Res #1 to any State agencies. The ADM stated that she received a text message from the facility at approximately 2:00 AM on 07/26/2021 that Res #1 had set a small fire with a piece of paper. The ADM did not conduct an investigation and did not report the fire. The ADM confirmed that she had not obtained any statements from Res #1 and had not updated and/or revised his plan of care or behavioral health assessments. ADM stated that it was her thoughts that Res #1 set the fire because he was use to setting fires due to his being homeless and living on the streets. ADM stated that the staff were verbally informed that a fire had occurred on 07/26/2021. The ADM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 609	Continued From page 10	F 609		

stated that she realized now that she had made a mistake by not reporting the fire of 07/26/2021 set by Res #1. ADM stated that they did not conduct a thorough investigation of the fire on 07/26/2021 and that they did not place Res #1 on close observation after the fire on 07/26/2021. The ADM stated that Resident #1 was not a smoker and they were not able to predict that a non-smoker would have a cigarette lighter.

Record review of the admission "History and Physical" for Res #1, completed on July 1, 2021 by the facility's Doctor of Nurse Practitioner (DNP) NP, documented: "Social History: Light Smoker Etoh (alcohol) 6 cans a week H/O (history of) marijuana use."

Interview on 08/11/2021 at 4:48 PM, with the Corporate Regional Director, revealed that the ADM had contacted him about the fire after it happened on 07/26/2021 and had reported to him that it was a "small fire caused by a piece of paper that was lit on fire" and that it involved no injuries and the fire was put out easily by an employee with no incidents. The Regional Director confirmed that he had told the ADM not to report the fire to any of the State agencies because it was a non-reportable incident that did not involve abuse.

Interview on 08/12/2021 at 12:40 P.M. with LPN#2, the night shift nurse on second floor assigned to Resident #1 on 7/26/2021. LPN#2 confirmed that she was a witness to the fire set by Res #1 on 07/26/2021. LPN #2 stated that the ADM nor the DON had spoken to her about the fire and no investigation had been conducted to her knowledge. LPN#2 stated that LPN #3 had told her to write a brief statement on a piece of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 609	Continued From page 11	F 609		

plain paper and put it in an envelope and leave it at the nursing station for the DON to pick up the next morning. LPN #2 stated that she had not been spoken to about the fire since it happened on 07/26/2021 at 1:30 AM. LPN #2 stated that she stayed over until the morning shift and verbally reported what had happened with the fire to the morning staff, and she called the social worker to come up and talk to Res #1 because she thought he may need to have a talk with some staff that knew him better.

Interview on 08/12/2021 at 8:30 P.M. with LPN#1, revealed that she had been the one that put the fire out on the unit. LPN #1 stated that LPN #2 had talked to LPN #3 and was told by the ADM not to document the fire and to not put anything in the computer or in the 24 hour report book that the fire had occurred. LPN #1 stated that she had worked at the facility for years prior and had worked at State Hospital for 17 years prior and that fires had to be well documented and statements taken from all involved. LPN#1 had never been told, until 07/26/2021, to not document a fire. LPN #1 stated that she felt that it was wrong to not report the fire and/or to not document the events of the fire, but she and LPN #2 did what they were instructed to do by LPN #3, who had talked to the ADM.
LPN #1 stated that she gave a written statement, for the first time, to the ADM on Tuesday morning 08/10/2021 after the surveyors entered the facility.

Interview on 08/14/2021 at 10:54 A.M. with (LPN #3) revealed that she had been the first floor LPN on 07/26/2021. LPN #3 called the Maintenance Director, to tell him of the fire and to get instructions as to how to turn off the fire alarm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 609	Continued From page 12	F 609		

LPN #3 stated that she called the ADM and DON and they told her to relay to the staff up on second floor not to document the fire in the computer and not to document in the medical records of Res #1. LPN #3 went back upstairs and told the LPN #1 and LPN #2 not to document the fire, as she had been told by the ADM. LPN #3 stated that she had not been asked about the fire on 07/26/2021 and had not given a statement about the fire until 08/10/2021. LPN #3 has no knowledge of the fire having been reported and or investigated prior to 08/10/2021.

Interview on 08/14/2021 at 1:30 P.M. with CNA #1 revealed that she was the second floor CNA on 07/26/2021 and she was the one that discovered the fire burning in the hallway outside of Resident #1's room. CNA #1 stated that she did not document the fire and she was not asked to document any information.

REMOVAL PLAN

The facility submitted a Removal Plan for the IJ. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ:

Brief Summary of Events

On 7//26/21 at approximately 1:30 am Licensed Practical Nurse LPN#1 reported witnessing a small fire and heard fire alarm sounding simultaneously. Fire was located in middle of second floor A wing hall outside of Resident #1's room (210). Fire was located in center hall not encountering outside walls. LPN (Licensed Practical Nurse) #1 immediately extinguished fire by smothering with a blanket. LPN #! inspected

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 609	Continued From page 13	F 609		

area surrounding previous fire for any further active fires with none found. LP #2 contacted local fire department. LPN #1 and LPN #3 were going room to room with in location of the incident and reported Resident #1 was up sitting on edge of the bed upon entering the room. LPN #1 questioned Resident #1 on awareness of fire starting. Resident #1 reported he lit the fire because he was cold but when he started to get hot, he threw it out the room. Resident #1 was immediately assessed by LPN #1 for any injury with no injuries found. Resident#1 reported he was in possession of a lighter. Lighter was removed by LPN #1. After room search completed, a second lighter was removed by LPN #3. Resident #1 denied any pain. Resident #1 refused to answer on where he obtained the lighter from. Resident #1 reported he had lighter to keep him warm. No other Residents were in surrounding incident. Resident #1 had no roommate.

Corrective Actions

1- On 07/26/21 at approximately 1:30 A.M. LPN #2 called 91 1 while facility alarm was sounding. Sprinkler systems were not activated as fire induced levels did not reach needed levels to activate.

2 -On 7/26/21 at approximately 1:33 A.M. Resident #1 was assessed by LPN #1 and found to have no injuries. The facility has no outside legal representative for Resident #1. Resident #1 is his own Responsible Party.

3- On 7/26/21 at 1:39 A.M. Yazoo City File Department arrived on scene.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 609	Continued From page 14	F 609		

4.- On 7/26/21 at 1:43 A-M. LPN#2 contacted Administrator and Director of Nursing via text message.

5.- On 7/26/21 at 1:50 A. M. Administrator contacted facility.

6.- On 7/26/21 at I A.M. Yazoo City Fire Department cleared the scene and departed the facility.

7.- On 7/26/21 beginning at approximately 8:30 A.M. Director of Nursing, RN Supervisor #1, RN Supervisor #2, Assistant Director of Nursing (ADON), Medical Records, and Activity Director began resident room checks of the entire facility to ensure all lighters were removed. Room checks were completed and no lighters were found.

8.- On 7/26/21 beginning at approximately 10:30 A.M. Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, Licensed Nurses, housekeeping staff, business office staff, therapy staff, dietary staff, and administrative staff on Abuse and Neglect Prohibition Policy and Flammable materials and storage.

9.- On 7/28/21 at 12:30 P.M., the Medical Director, Administrator, Director Assistant Director of Nursing, Social Services, Nurse Practitioner, Activity Director Business Office Manager, Wound Care Nurse and Medical Records held Quality Assurance Performance Improvement Committee meeting where the file was discussed and Resident Safety.

10.- On 8/10/21 at approximately 12:30 P.M.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 609	Continued From page 15	F 609		

Psychiatric Nurse Practitioner #1 assessed Resident #1 fi)r psychosocial, emotional, and mental distress along with a review of all of Resident #1 current medications. Psychiatric Nurse Practitioner #1 recommended a medication addition to assist with anxiousness- Resident #1 declined medication

11.- On 8/10/21 at 4:02 P.M. State Agency (SA) notified facility Administrator, Director Nursing and Assistant Director of Nursing of Immediate Jeopardy (IJ) with substandard quality of care. State Agency Surveyor provided the facility with the Immediate Jeopardy (IJ) templates.

12.- On 8/10/21 at approximately 5:15 P.M. Director of Nursing, RN Supervisor #1, RN Supervisor #2, RN Supervisor #3, Assistant Director of Nursing (ADON), Medical Records, Business Office Manager, Assistant Business Office Manager, Admission Coordinator, Maintenance Director, and Activity Director began resident room cheeks to ensure that all lighters were removed. Room checks were completed, and no lighters were found. Room checks completed at approximately 6:00 P.M. on 8/10/21 of all rooms in the building.

13.- On 8/10/21 at 7:09 P.M. facility Administrator initiated automated phone reporting system alert to resident families and staff of combustible safety storage, including facility storage of lighters, asking families not to purchase flammable materials including new policy implementation of combustible safety to use in conjunction with the current fire prevention policy. This combustible safety policy was created by the Quality Assurance Performance Improvement committee and approved by the facility medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 609	Continued From page 16	F 609		

director. The system automatically sends alerts and contacts families and staff listed in resident's records and payroll system.

14.- On 8/10/21 beginning at 8:15 P.M. Staff Development Coordinator initiated education on Combustible Safety storage and fire prevention with staff and residents to include Certified Nursing Assistants, Licensed nurses, housekeeping staff, Business Office staff, Therapy staff, Dietary staff, and administrative staff on new Combustible Safety Policy. No staff will be allowed to work without completing.

15.- On 8/10/21 at 9:00 P.M. Mississippi State Department of Health notified of event and pending Life Safety notification.

16.- On 8/1 1/21 at 10:30 A.M Mississippi State Department of Life Safety notified of fire with unusual incident report submitted.

17.- On 8/11/21 at 10:45 A.M. Medical Director, Administrator, Director of Nursing, RN Superviseor and RN Supervisor #4, LPN #4 held Quality Assurance Performance Improvement Meeting to include notification of Immediate Jeopardy to review steps initiated to prevent any further occurrence including new policy on Combustible Safety Storage. Policy includes no flammable materials in Resident's possession regardless of smoking status.

18.- On 8/11/21 at 9:30 A.M. Resident Council Meeting Held with Activity Director, Activity Assistant, Admission Coordinator, Resident Council President, and 13 total residents were present to discuss the new policy on Combustible Safety to include facility storage of flammable

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 609	Continued From page 17	F 609		

materials regardless of smoking status.

19.- On 8/11/21 at 5:30 P.M. Mississippi State Department of Health added 3 additional Immediate Jeopardy's (IJ).

20.- On 08/11/21 at 6:00 P.M. Resident had a Smoking evaluation completed by Director of Nursing (DON) and deemed currently as non-smoker. This is second smoking evaluation completed on Resident since admission which was on 6/29/21.

21.- On 8/11/2021 at 6:45 P.M. Social Services Director (SSD) developed a plan of care based on Resident #1 hallucinations occurring on 7/26/21. Adjustments to be made to the plan of care in event of further behaviors on an as needed basis.

22.- On 08/11/2021 at 7:15 P.M. Psychosocial interviews were completed by Administrator #2 and Area Director of Business Development (ADBD)on eight (8) Residents with BIMS (Brief Interview Mental Status) of 13 or higher in the seven (7) surrounding rooms to Resident to assess for psychosocial, emotional. or mental distress surrounding fire event with no emotional concerns noted.

23.- On 8/11/2021 at 7:19 P.M. a body audit was completed on Resident #1 by the MDS (Minimum Data Set) Coordinator to assess for any injuries with no negative findings.

24.- On 08/1 1/2021 at 7:30 P-M. the Administrator and Director of Nursing received education on proper Abuse and Neglect Reporting and investigation guidelines following

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 609	Continued From page 18	F 609		

State and Federal Regulations by Senior Administrator from a sister facility.

25.- On 08/11/2021 at 8:40 P.M. Medical Director. Administrator, Director of Nursing, Corporate Clinical Specialist (CCS) and Area Director of Business Development (ADBD)held an Ad-Hoc Quality Assurance Performance Improvement Meeting to include notification of additional Immediate Jeopardy (IJ) tags F610, F656 and F742 with no further recommendations.

26.- On 8/11/2021 at approximately 9:30 P.M. in-services were initiated to include Care Plans with a focus on behaviors and investigations of unusual occurrences. No staff members will be able to work until they are in-serviced.

27.- Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of 08/11/21, and the Immediate Jeopardy was removed 08/12/21.

On Saturday August 14, 2021 the State Agency (SA) validated the facility's Removal Plan for the Immediate Jeopardy (IJ). Validations of the facility's Removal Plan was conducted through staff interview, observations, policy and procedure review, and record reviews. The SA's validations on 08/14/2021 revealed that the facility took the following actions to remove the IJ:

1-The SA validated through interview with LPN#3 on 08/14/2021 at 10:54 AM that on 07/26/21 at approximately 1:30 AM the facility fire alarm was sounding and the facility sprinkler systems were not activated as fire induced levels did not reach needed levels to activate the sprinkler system. LPN#3 validated that she called the Maintenance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 609	Continued From page 19	F 609		

Director on 07/26/2021 at approximately 2:00 AM to obtain instructions as to how to reset the fire alarm after the fire had been extinguished by the facility staff.

2 -The SA validated through interview on 08/14/2021 at 10:54 AM with LPN#3, that she and LPN#1 had verbally assessed resident #1 on 7/26/21 at approximately 1:33 AM Resident #1 was verbally assessed by LPN #1 and found to have no injuries. The facility has no outside legal representative for Resident #1. Resident #1 is his own Responsible Party.

3- On 08/14/2021 at 9:00 AM the SA validated through record review of the City Fire Department's written report, that on 7/26/21 at 1:39 AM the City File Department arrived on the scene at the facility and the facility ' s fire alarm was sounding. Record review of the written City Fire Report validated that the fire was extinguished prior to their arrival at the facility.

4.- The SA validated through interview on 08/14/2021 at 10:54 AM with LPN#3 that on 7/26/21 at approximately 1:43 AM. LPN#3 had contacted the Administrator and Director of Nursing via text message that there had been a fire at the facility on 07/26/2021.

5.-The SA validated through interview on 08/14/2021 at 10:54 AM with LPN#3 that on 7/26/21 at 1:50 AM the Administrator contacted LPN#3 concerning the fire.

6.- The SA validated on 08/14/2021 through record review of the City Fire Department's Report that on 7/26/21 at 1:53 AM the City Fire Department cleared the scene and departed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 609	Continued From page 20	F 609		

facility. The SA also validated through interview on 08/14/2021 at 10:54 AM with LPN#3 that the City Fire Department came to the facility on 07/26/2021 at approximately 1:30 AM and left the facility at approximately 1:53 AM on 07/26/2021.

7.- The SA validated on 08/14/2021 through record review that on 7/26/21 beginning at approximately 8:30 AM Director of Nursing, RN Supervisor #1, RN Supervisor #2, Assistant Director of Nursing (ADON), Medical Records, and Activity Director began resident room checks of the entire facility to ensure all lighters were removed. Room checks were completed and no lighters were found.

8.-The SA validated on 08/14/2021 through record review of the In-Services sign-in/attendance sheets, that on 7/26/21 beginning at approximately 10:30 AM Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, Licensed Nurses, housekeeping staff, business office staff, therapy staff, dietary staff, and administrative staff on Abuse and Neglect Prohibition Policy and Flammable materials and storage.

9.- The SA validated through interview, and record review of the QA Meeting ' s sign-in/attendance sheet dated 07/28/2021, and with the facility Administrator (ADM) interview on 08/14/2021 at 10:00 AM that on 7/28/21 at 12:30 PM, the Medical Director, Administrator, Director Assistant Director of Nursing, Social Services, Nurse Practitioner, Activity Director Business Office Manager, Wound Care Nurse and Medical Records held Quality Assurance Performance Improvement Committee meeting where the file

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 609	Continued From page 21	F 609		

was discussed and Resident Safety.

10.-On 08/14/2021 the SA validated through record review that on 8/10/21 at approximately 12:30 PM the facility's Psychiatric Nurse Practitioner assessed Resident #1 for psychosocial, emotional, and mental distress along with a review of all of Resident #1 current medications. Psychiatric Nurse Practitioner recommended a medication addition to assist with anxiousness- Resident #1 declined medication.

11.-The SA validated on 08/14/2021 through record review that the IJ Templates were provided to the facility on 8/10/21 at 4:02 PM the SA validated through record review, that the notification of the IJ was provided to the facility Administrator, Director Nursing and Assistant Director of Nursing. The validation on 08/14/2021 by record review documented that the Immediate Jeopardy (IJ) with Substandard Quality of Care was provided in writing, to the facility, per the submission of the IJ Templates dated 08/10/2021 at 4:02 PM.

12.-On 08/14/2021 the SA validated through record review that on 8/10/21 at approximately 5:15 PM Director of Nursing, RN Supervisor #1, RN Supervisor #2, RN Supervisor #3, Assistant Director of Nursing (ADON), Medical Records, Business Office Manager, Assistant Business Office Manager, Admission Coordinator, Maintenance Director, and Activity Director began resident room cheeks to ensure that all lighters were removed. Room checks were completed, and no lighters were found. Room checks completed at approximately 6:00 PM on 8/10/21 of all rooms in the building.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 609	Continued From page 22	F 609		

13.-The SA validated on 08/14/2021 at 10:00 A.M. through interview with the facility ADM that on 8/10/21 at 7:09 PM the facility Administrator initiated automated phone reporting system alert to resident families and staff of combustible safety storage, including facility storage of lighters, asking families not to purchase flammable materials including new policy implementation of combustible safety to use in conjunction with the current fire prevention policy. This combustible safety policy was created by the Quality Assurance Performance Improvement committee and approved by the facility medical director. The system automatically sends alerts and contacts families and staff listed in resident's records and payroll system.

14.- On 08/14/2021 the SA validated through a record review, the In-Service sign-in/attendance sheets dated 8/10/21, that beginning at 8:15 PM the Staff Development Coordinator initiated education on Combustible Safety storage and fire prevention with staff and residents to include Certified Nursing Assistants, Licensed nurses, housekeeping staff, Business Office staff, Therapy staff, Dietary staff, and administrative staff on new Combustible Safety Policy. No staff will be allowed to work without completing.

15.-On 08/14/2021 a record review validated that on 8/10/21 at 9:00 PM the facility notified the Mississippi State Department of Health of the 07/26/2021 fire event and of the pending Life Safety written notification.

16.- The SA validated through record review that on 08/14/2021 that on 8/11/21 at 10:30 AM Mississippi State Department of Life Safety

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 609	Continued From page 23	F 609		

notified of fire with unusual incident report submitted.

17.- The SA validated on 08/14/2021 through record review of the QA sign-in/attendance sheet and policy review that on 8/11/21 at 10:45 A.M. Medical Director. Administrator, Director of Nursing, RN Supervisor and LPN #4 held Quality Assurance Performance Improvement Meeting to include notification of Immediate Jeopardy to review steps initiated to prevent any further occurrence including new policy on Combustible Safety Storage. Policy includes no flammable materials in Resident's possession regardless of smoking status.

18.- The SA validated through record review on 08/14/2021 that on 8/11/21 at 9:30 A.M. the Resident Council Meeting was held with the Activity Director, Activity Assistant, Admission Coordinator, Resident Council President, and 13 total residents were present to discuss the new policy on Combustible Safety to include facility storage of flammable materials regardless of smoking status.

19.-The SA validated, through record review of the IJ Templates, on 08/14/2021, that on 8/11/21 at 5:30 PM the Mississippi State Department of Health added 3 additional Immediate Jeopardy's (IJ). The additional IJ's were provided to the facility per the written IJ Templates for F610; F656; and F742.

20.- The SA Validated through record review on 08/14/2021, that on 08/11/21 at 6:00 PM Resident #1 had a Smoking evaluation completed by the Director of Nursing (DON) and was deemed as a non-smoker. This was the second smoking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 609	Continued From page 24	F 609		

evaluation completed on Resident #1 since admission which was on 6/29/21.

21.-On 08/14/2021 at 11:50 P.M. the SA validated through an interview with the Social Services Director (SSD) and through record review of the care plan for Res #1, that on 8/11/2021 at 6:45 PM the Social Services Director (SSD) developed a Plan of Care based on Resident #1's hallucinations that occurred on 7/26/21.

22.-The SA validated through record review on 08/14/2021 that on 08/11/2021 at 7:15 PM Psychosocial interviews were completed by Administrator #2 and Area Director of Business Development (ADBD)on eight (8) Residents with BIMS (Brief Interview Mental Status) of 13 or higher in the seven (7) surrounding rooms to Resident to assess for psychosocial, emotional. or mental distress surrounding fire event with no emotional concerns noted.

23.- The SA validated through record review on 08/14/2021 that on 8/11/2021 at 7:19 PM a body audit was completed on Resident #1 by the MDS (Minimum Data Set) Coordinator to assess for any injuries with no negative findings.

24.- The SA validated through record review and through interview on 08/14/2021 at 10:00 A.M. with the facility ADM that on 08/11/2021 at 7:30 P-M. the Administrator and Director of Nursing received education on proper Abuse and Neglect Reporting and investigation guidelines following State and Federal Regulations by Senior Administrator from a sister facility.

25.- The SA validated on 08/14/2021 through record review of the QA sign-in/attendance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 609	Continued From page 25	F 609		

sheets that on 08/11/2021 at 8:40 P.M. Medical Director. Administrator, Director of Nursing, Corporate Clinical Specialist (CCS) and Area Director of Business Development (ADBD) held an Ad-Hoc Quality Assurance Performance Improvement Meeting to include notification of additional Immediate Jeopardy (IJ) tags F610, F656 and F742 with no further recommendations.

26.- On 08/14/2021 from 10:54 A.M.-12:05 P.M. the SA interviewed seven (7) CNA's; two (2) RN's; Two (2) dietary workers; two(2) office staff; two (2) house keeping staff; four (4) LPN's; two (2) Social Workers; the facility ADM and the DON, to validate that all staff working on 8/11/2021 at approximately 9:30 P.M. were in-serviced and validated that in-services were initiated to include Care Plans with a focus on behaviors and investigations of unusual occurrences. The SA validated through interview and record review on 08/14/2021 with the ADM and DON, that no staff members will be able to work until they are in-serviced.

27.-The SA validated on 08/14/2021 from 10:00 A.M. through 12:25 PM via observations, record reviews, staff interviews, and policy and procedure reviews that the facility submitted a Removal Plan for the IJ. The SA validated through record reviews, staff interviews, observations, and policy and procedure reviews, that the facility had completed all the tasks outlined in the Removal Plan on 08/11/2021 and the IJ 's were removed on 08/12/2021.

On 08/14/2021 the State Agency (SA) validated, through interviews, record reviews, observations and policy and procedure reviews, that all corrective actions to remove the IJ, were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 609	Continued From page 26 completed on 08/11/2021 and the IJ was removed on 08/12/2021.	F 609		
F 610 SS=J	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews, resident interviews, and policy and procedure reviews the facility failed to thoroughly investigate a facility fire that was set by Resident #1 when he ignited his bed linen with a cigarette lighter and threw them out in to the hallway which resulted in a facility fire. Resident #1 was one (1) of seven (7) residents reviewed for thorough investigations after an accident/hazard. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 07/26/2021, regarding the	F 610	1. On 07/26/21 at approximately 1:30 A.M. LPN #2 called 911 while facility alarm was sounding. Sprinkler systems were not activated as fire induced levels did not reach needed levels to activate. On 7/26/21 at approximately 1:33 A.M. Resident #1 was assessed by LPN #1 and found to have no injuries. The facility has no outside legal representative for Resident #1. Resident #1 is his own responsible party. On 7/26/21 at 1:39 A.M. Yazoo City Fire Department arrived on scene. On 7/26/21 at 1:43 A.M. LPN#2	9/13/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 610	Continued From page 27 facility's noncompliance in thoroughly investigating a facility fire set by Resident #1 on 07/26/2021. The facility failed to supervise and thoroughly assess Resident #1 to avoid the potential for danger to Resident #1 and to the other facility residents and staff. Resident #1 started a facility fire on 07/26/2021 at approximately 1:30 AM when he set his bed linen on fire with a cigarette lighter and threw it out into the hallway of the facility which activated the facility fire alarm and summoned/deployed the fire department to the facility. Immediately following the fire on 07/26/2021 at approximately 1:30 AM, the facility failed to thoroughly investigate the fire, and failed to report the fire as required per Federal and State regulations. The facility failed to devise/revise the comprehensive plan of care for Resident #1 after he ignited his bed linen with a cigarette lighter causing a facility fire of 07/26/2021. The facility failed to thoroughly assess Resident #1's mental and behavioral health in order to address his psychosocial well-being. The facility failed to obtain the appropriate mental health and behavioral health services to address Resident #1's psychosocial well-being after the fire occurred on 07/26/2021. The facility's failure to adequately supervise Resident #1 resulted in his setting his bed linen on fire with a cigarette lighter and throwing it out in to the hallway of the facility which placed this resident and other residents who reside in the facility in a situation that was likely to cause serious harm, injury, impairment or death. On 08/10/2021 at 4:02 PM, the State Agency (SA) notified the facility Administrator of the IJ and SQC and the facility was presented with the IJ templates.	F 610	contacted Administrator and Director of Nursing via text message. On 7/26/21 at 1:50 A. M. Administrator contacted facility. On 7/26/21 at 1:53 A.M. Yazoo City Fire Department cleared the scene and departed the facility. On 7/26/21 beginning at approximately 8:30 A.M. Director of Nursing, RN Supervisor #1, RN Supervisor #2, Assistant Director of Nursing (ADON), Medical Records, and Activity Director began resident room checks of the entire facility to ensure all lighters were removed. Room checks were completed, and no lighters were found. On 7/26/21 beginning at approximately 10:30 A.M. Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, Licensed Nurses, housekeeping staff, business office staff, therapy staff, dietary staff, and administrative staff on Abuse and Neglect Prohibition Policy and Flammable materials and storage. On 7/28/21 at 12:30 P.M., the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Social Services, Nurse Practitioner, Activity Director Business Office Manager, Wound Care Nurse and Medical Records held Quality Assurance Performance Improvement Committee meeting where the fire was discussed and Resident Safety. 2. All residents have the potential to be affected. 3. On 08/11/2021 Staff Development	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 610	Continued From page 28 The facility submitted an acceptable Removal Plan on 08/12/2021 at 2:29 PM, in which the facility alleged all corrective actions to remove the IJ's were completed on 08/11/2021 and the IJ's were removed on 08/12/2021. The State Agency (SA) validated the Removal Plan on 08/14/2021 and determined the IJ's were removed on 08/12/2021, prior to exit. Therefore, the Scope and Severity for 42 CFR(s): 483.12(c)(2)Investigate/Prevent/Correct Alleged Violations (F610), was lowered from a "J" to a "D," while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with the regulatory standards. Findings include: The facility policy and procedure titled, "Policy for Resident Incident and Visitor Accident Report", revised 7/23/18 and reviewed 10/08/2020 revealed, "The facility will conduct an investigation of all incidents involving residents of the facility...The investigation will be conducted by designated personnel and reported to the Administrator/designee... Procedure: Reporting of Resident Incidents and Visitor Accidents: Any employee witnessing or having knowledge of an incident or accident involving a resident or visitor must immediately report such occurrence to his/her supervisor... Regardless of how minor an incident/accident appears to be, it must be reported to the Department Supervisor, Administrator, or DON/designee. As soon as possible after becoming aware of an incident/accident, the Witness Form must be completed by any person witnessing the incident or any person thought to have witnessed the	F 610	Coordinator began education with nursing, administrative, housekeeping, dietary, and contract staff to including Abuse and Neglect Policy, reporting requirements and investigations to include unusual occurrences. 4. Beginning on 8/12/2021 Corporate Clinical Specialist will review all reportable investigations completed by facility to ensure full investigation components met for the next twelve weeks. Any concerns will be immediately addressed by the Administrator or Director of Nursing for further intervention. A report beginning on 8/18/21 will be submitted to the Quality Assurance Performance Improvement committee monthly for three (3) months for review and recommendations. The Administrator is responsible for monitoring 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 _____	C 08/14/2021

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 610	Continued From page 29	F 610		

incident. An Incident Report must be completed by the person reporting the incident or the supervisor on the shift that the incident occurred. The Investigation must be initiated by the Department Supervisor or Charge Nurse and completed by the Administrator or DON/designee..."

Record review of the "Abuse Prohibition Policy", dated original 5/01/01 reviewed 10/8/2020 revision 5/28/2021 revealed ...All new current employees will receive training and reinforcement on all aspects of this abuse prohibition program. This will be done at the time of initial employee orientation, annually, and through ongoing in-service ....Investigation: 1. The facility will thoroughly investigate all alleged violations and take appropriate actions ...3. The facility will report the results of the investigation to the enforcement agency in accordance with state law, including the state agency and certification agency ...5. Investigations will be prompt, comprehensive and responsive to the situation and contain founded conclusions ..."

Observation on 08/10/2021 at 6:15 A.M. revealed that the floor in the hallway in front of Resident #1's room had an area of moderate size to be discolored with brown marks that would not rub off when surveyor rubbed the brown marks with her shoes.

Interview on 8/10/2021 at 6:54 AM,. with the Director of Nursing (DON) revealed that she had no knowledge of a fire at the facility in July 2021. The DON stated that she had been off some in July 2021 and possibly there had been a fire that she was not informed had occurred. The DON stated that she would go check her records to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 610	Continued From page 30	F 610		

see if a fire was reported without her knowledge.

Interview and observation on 08/10/2021 at 7:38 AM, with Resident #1 stated that he was "having one of those bad days." He stated: "I really don't know what happened." He said that he really believed that he was on too much medicine and that being over medicated caused him to set the fire. Res #1 stated that he had a lighter that he had brought to the facility in his bag upon admission. Res #1 stated that he had been admitted to the facility about a month when he set the fire. Res #1 stated that he use to smoke but "I don't smoke anymore" and confirmed that he set the fire with his lighter that he had in his room. Res #1 stated that he felt bad most of the time and was in a lot of pain. Res #1 stated that he really did not know what he set on fire or where he got it from "but I threw it out into the hallway." He stated that the fire department did come to the unit for the fire and that the fire alarm was sounded when he threw the fire out into the hallway. Res #1 stated that he knew now that he was not suppose to have a lighter in his possession. Res #1 stated that the fire had burned the floor tiles in front of his bedroom. He denied any injury from the fire and stated, "I was ok, I did not get hurt." During the interview, he had rapid disconnected speech. At times, when he was talking, he appeared to loose his concentration. At times, during the interview, Res #1 was difficult to understand. He rambled and mumbled in a soft "rapid" low voice. Res #1 stated that he had not visited with a doctor since the fire and had not left the facility. He stated, "I don't know what made me do it. It was one of those bad days. I started hollering 'fire' and the staff came and got it out."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 610	Continued From page 31	F 610		

Interviews on 08/10/2021 at 7:57 A.M. with the facility Administrator (ADM) and the facility Director of Nursing (DON) revealed the DON stated that she had received a text message that there was a possible "paper" fire that the nurse had put out with a blanket. The ADM stated that there had not been an investigation completed because there was nothing to investigate, the nurse had put the fire out prior to the fire department's arrival and it was "very small." ADM stated that the fire department was called but they did not have to do anything because the small fire was out when the fire department got to the facility. The ADM and DON stated that they were not sure of the exact date of the second fire but that it was 2-3 weeks prior to 08/10/2021. The ADM stated: "We will have to look at the text messages in our phones to get the date of the fire." The DON and ADM did not give any details or names involved with the "second floor" facility fire.

Interview on 08/10/2021 at 10:49 A.M. with the two Social Services (2) SS's revealed that they were told by the ADM on 07/26/2021 not to document the incident of the fire set by Res #1 in the computer or in the Medical Record of Res #1. The ADM told them to make a written statement and to give it only to her to keep in her office in a "Hot File." The SS's stated that they are totally an electronic charting system and there were no paper charts in the facility. The hand written statements that they made were given to the ADM to keep in her office.

Interview on 08/10/2021 at 3:15 P.M. with the City Fire Chief, revealed that the report was signed by another firemen that had attended to the fire at the facility on 07/26/2021. Fire Chief stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 610	Continued From page 32	F 610		

the fire alarm did sound and the fire department did come to the facility early in the morning just after midnight at approximately 1:39 A.M. on 07/26/2021. The alarm was sounding when they arrived at the facility and the fire had been put out by a nurse on the second floor of the facility.

Record review of the City Fire Dept Report confirmed that the 911 call was dispatched through the 911 services. The 911 dispatch report was obtained and reviewed. The report documented the fire alarm dispatched the Fire Department at 1:31 A.M. and the Fire Department arrived at 1:39 A.M. The fire was controlled at 1:53 A.M. and the unit was cleared at 1:53 A.M. No other details were documented on the fire department report or the 911 dispatch report.

Interview on 08/10/2021 at 3:51 P.M. with the ADM and the DON confirmed that they had not investigated the fire set by Res #1 on 07/26/2021. The ADM stated that she received a text message from the facility at approximately 2:00 A.M. on 07/26/2021 that Res #1 had set a small fire with a piece of paper. The ADM did not conduct an investigation and did not report the fire. The ADM confirmed that she had not obtained any statements from Res #1.

Interview on 08/12/2021 at 12:40 P.M. with LPN#2, night shift nurse on second floor. LPN#2 confirmed that she was a witness to the fire set by Res #1 on 07/26/2021. She stated LPN #3 called the DON and the ADM and then came and told LPN#2 not to document the fire in the computer and not to document the fire on the 24 hour report like was usually done. LPN #2 stated that the ADM nor the DON had spoken to her about the fire and no investigation had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 610	Continued From page 33	F 610		

conducted to her knowledge. LPN#2 stated that LPN #3 had told her to write a brief statement on a piece of plain paper and put it in an envelope and leave it at the nursing station for the DON to pick up the next morning. LPN #2 stated that she had not been spoken to about the fire since it happened on 07/26/2021 at 1:30 AM.

Interview on 08/12/2021 at 8:30 PM, with LPN#1, revealed that she had been the one that put the fire out on the unit. LPN #1 stated that LPN #2 had talked to LPN #3 and was told by the ADM not to document the fire and to not put anything in the computer or in the 24 hour report book that the fire had occurred. LPN #1 stated that she had worked at the facility for years prior and had worked at State Hospital for 17 years prior and that fires had to be well documented and statements taken from all involved. LPN#1 had never been told, until 07/26/2021, to not document a fire. LPN #1 stated that she felt that it was wrong to not report the fire and/or to not document the events of the fire, but she and LPN #2 did what they were instructed to do by LPN #3, who had talked to the ADM. LPN #1 stated that she gave a written statement, for the first time, to the ADM on Tuesday morning 08/10/2021 after the surveyors entered the facility.

Interview on 08/14/2021 at 10:54 A.M. with (LPN #3) revealed that she had been the first floor LPN on 07/26/2021. LPN #3 stated that she called the ADM and DON and they told her to relay to the staff up on second floor not to document the fire in the computer and not to document in the medical records of Res #1. LPN #3 went back upstairs and told the LPN #1 and LPN #2 not to document the fire, as she had been told by the ADM. LPN #3 stated that she had not been asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 610	Continued From page 34	F 610		

about the fire on 07/26/2021 and had not given a statement about the fire until 08/10/2021. LPN #3 has no knowledge of the fire having been investigated prior to 08/10/2021.

REMOVAL PLAN

The facility submitted a Removal Plan for the IJ. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ:

Brief Summary of Events

On 7//26/21 at approximately 1:30 am Licensed Practical Nurse LPN#1 reported witnessing a small fire and heard fire alarm sounding simultaneously. Fire was located in middle of second floor A wing hall outside of Resident #1's room (210). Fire was located in center hall not encountering outside walls. LPN (Licensed Practical Nurse) #1 immediately extinguished fire by smothering with a blanket. LPN #! inspected area surrounding previous fire for any further active fires with none found. LP #2 contacted local fire department. LPN #1 and LPN #3 were going room to room with in location of the incident and reported Resident #1 was up sitting on edge of the bed upon entering the room. LPN #1 questioned Resident #1 on awareness of fire starting. Resident #1 reported he lit the fire because he was cold but when he started to get hot, he threw it out the room. Resident #1 was immediately assessed by LPN #1 for any injury with no injuries found. Resident#1 reported he was in possession of a lighter. Lighter was removed by LPN #1. After room search completed, a second lighter was removed by LPN #3. Resident #1 denied any pain. Resident #1 refused to answer on where he obtained the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 610	Continued From page 35	F 610		

lighter from. Resident #1 reported he had lighter to keep him warm. No other Residents were in surrounding incident. Resident #1 had no roommate.

Corrective Actions

1- On 07/26/21 at approximately 1:30 A.M. LPN #2 called 91 1 while facility alarm was sounding. Sprinkler systems were not activated as fire induced levels did not reach needed levels to activate.

2 -On 7/26/21 at approximately 1:33 A.M. Resident #1 was assessed by LPN #1 and found to have no injuries. The facility has no outside legal representative for Resident #1. Resident #1 is his own Responsible Party.

3- On 7/26/21 at 1:39 A.M. Yazoo City File Department arrived on scene.

4.- On 7/26/21 at 1:43 A-M. LPN#2 contacted Administrator and Director of Nursing via text message.

5.- On 7/26/21 at 1:50 A. M. Administrator contacted facility.

6.- On 7/26/21 at I A.M. Yazoo City Fire Department cleared the scene and departed the facility.

7.- On 7/26/21 beginning at approximately 8:30 A.M. Director of Nursing, RN Supervisor #1, RN Supervisor #2, Assistant Director of Nursing (ADON), Medical Records, and Activity Director began resident room checks of the entire facility to ensure all lighters were removed. Room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 610	Continued From page 36	F 610		

checks were completed and no lighters were found.

8.- On 7/26/21 beginning at approximately 10:30 A.M. Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, Licensed Nurses, housekeeping staff, business office staff, therapy staff, dietary staff, and administrative staff on Abuse and Neglect Prohibition Policy and Flammable materials and storage.

9.- On 7/28/21 at 12:30 P.M., the Medical Director, Administrator, Director Assistant Director of Nursing, Social Services, Nurse Practitioner, Activity Director Business Office Manager, Wound Care Nurse and Medical Records held Quality Assurance Performance Improvement Committee meeting where the file was discussed and Resident Safety.

10.- On 8/10/21 at approximately 12:30 P.M. Psychiatric Nurse Practitioner #1 assessed Resident #1 for psychosocial, emotional, and mental distress along with a review of all of Resident #1 current medications. Psychiatric Nurse Practitioner #1 recommended a medication addition to assist with anxiousness- Resident #1 declined medication

11.- On 8/10/21 at 4:02 P.M. State Agency (SA) notified facility Administrator, Director Nursing and Assistant Director of Nursing of Immediate Jeopardy (IJ) with substandard quality of care. State Agency Surveyor provided the facility with the Immediate Jeopardy (IJ) templates.

12.- On 8/10/21 at approximately 5:15 P.M. Director of Nursing, RN Supervisor #1, RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 610	Continued From page 37	F 610		

Supervisor #2, RN Supervisor #3, Assistant Director of Nursing (ADON), Medical Records, Business Office Manager, Assistant Business Office Manager, Admission Coordinator, Maintenance Director, and Activity Director began resident room cheeks to ensure that all lighters were removed. Room checks were completed, and no lighters were found. Room checks completed at approximately 6:00 P.M. on 8/10/21 of all rooms in the building.

13.- On 8/10/21 at 7:09 P.M. facility Administrator initiated automated phone reporting system alert to resident families and staff of combustible safety storage, including facility storage of lighters, asking families not to purchase flammable materials including new policy implementation of combustible safety to use in conjunction with the current fire prevention policy. This combustible safety policy was created by the Quality Assurance Performance Improvement committee and approved by the facility medical director. The system automatically sends alerts and contacts families and staff listed in resident's records and payroll system.

14.- On 8/10/21 beginning at 8:15 P.M. Staff Development Coordinator initiated education on Combustible Safety storage and fire prevention with staff and residents to include Certified Nursing Assistants, Licensed nurses, housekeeping staff, Business Office staff, Therapy staff, Dietary staff, and administrative staff on new Combustible Safety Policy. No staff will be allowed to work without completing.

15.- On 8/10/21 at 9:00 P.M. Mississippi State Department of Health notified of event and pending Life Safety notification.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 610	Continued From page 38	F 610		

16.- On 8/1 1/21 at 10:30 A.M Mississippi State Department of Life Safety notified of fire with unusual incident report submitted.

17.- On 8/11/21 at 10:45 A.M. Medical Director. Administrator, Director of Nursing, RN Superviseor and RN Supervisor #4, LPN #4 held Quality Assurance Performance Improvement Meeting to include notification of Immediate Jeopardy to review steps initiated to prevent any further occurrence including new policy on Combustible Safety Storage. Policy includes no flammable materials in Resident's possession regardless of smoking status.

18.- On 8/11/21 at 9:30 A.M. Resident Council Meeting Held with Activity Director, Activity Assistant, Admission Coordinator, Resident Council President, and 13 total residents were present to discuss the new policy on Combustible Safety to include facility storage of flammable materials regardless of smoking status.

19.- On 8/11/21 at 5:30 P.M. Mississippi State Department of Health added 3 additional Immediate Jeopardy's (IJ).

20.- On 08/11/21 at 6:00 P.M. Resident had a Smoking evaluation completed by Director of Nursing (DON) and deemed currently as non-smoker. This is second smoking evaluation completed on Resident since admission which was on 6/29/21.

21.- On 8/11/2021 at 6:45 P.M. Social Services Director (SSD) developed a plan of care based on Resident #1 hallucinations occuring on 7/26/21. Adjustments to be made to the plan of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 610	Continued From page 39	F 610		

care in event of further behaviors on an as needed basis.

22.- On 08/11/2021 at 7:15 P.M. Psychosocial interviews were completed by Administrator #2 and Area Director of Business Development (ADBD)on eight (8) Residents with BIMS (Brief Interview Mental Status) of 13 or higher in the seven (7) surrounding rooms to Resident to assess for psychosocial, emotional. or mental distress surrounding fire event with no emotional concerns noted.

23.- On 8/11/2021 at 7:19 P.M. a body audit was completed on Resident #1 by the MDS (Minimum Data Set) Coordinator to assess for any injuries with no negative findings.

24.- On 08/1 1/2021 at 7:30 P-M. the Administrator and Director of Nursing received education on proper Abuse and Neglect Reporting and investigation guidelines following State and Federal Regulations by Senior Administrator from a sister facility.

25.- On 08/11/2021 at 8:40 P.M. Medical Director. Administrator, Director of Nursing, Corporate Clinical Specialist (CCS) and Area Director of Business Development (ADBD)held an Ad-Hoc Quality Assurance Performance Improvement Meeting to include notification of additional Immediate Jeopardy (IJ) tags F610, F656 and F742 with no further recommendations.

26.- On 8/11/2021 at approximately 9:30 P.M. in-services were initiated to include Care Plans with a focus on behaviors and investigations of unusual occurrences. No staff members will be able to work until they are in-serviced.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 610	Continued From page 40	F 610		

27.- Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of 08/11/21, and the Immediate Jeopardy was removed 08/12/21.

On Saturday August 14, 2021 the State Agency (SA) validated the facility's Removal Plan for the Immediate Jeopardy (IJ). Validations of the facility's Removal Plan was conducted through staff interview, observations, policy and procedure review, and record reviews. The SA's validations on 08/14/2021 revealed that the facility took the following actions to remove the IJ:

1-The SA validated through interview with LPN#3 on 08/14/2021 at 10:54 AM that on 07/26/21 at approximately 1:30 AM the facility fire alarm was sounding and the facility sprinkler systems were not activated as fire induced levels did not reach needed levels to activate the sprinkler system. LPN#3 validated that she called the Maintenance Director on 07/26/2021 at approximately 2:00 AM to obtain instructions as to how to reset the fire alarm after the fire had been extinguished by the facility staff.

2 -The SA validated through interview on 08/14/2021 at 10:54 AM with LPN#3, that she and LPN#1 had verbally assessed resident #1 on 7/26/21 at approximately 1:33 AM Resident #1 was verbally assessed by LPN #1 and found to have no injuries. The facility has no outside legal representative for Resident #1. Resident #1 is his own Responsible Party.

3- On 08/14/2021 at 9:00 AM the SA validated through record review of the City Fire Department's written report, that on 7/26/21 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 610	Continued From page 41	F 610		

1:39 AM the City File Department arrived on the scene at the facility and the facility ' s fire alarm was sounding. Record review of the written City Fire Report validated that the fire was extinguished prior to their arrival at the facility.

4.- The SA validated through interview on 08/14/2021 at 10:54 AM with LPN#3 that on 7/26/21 at approximately 1:43 AM. LPN#3 had contacted the Administrator and Director of Nursing via text message that there had been a fire at the facility on 07/26/2021.

5.-The SA validated through interview on 08/14/2021 at 10:54 AM with LPN#3 that on 7/26/21 at 1:50 AM the Administrator contacted LPN#3 concerning the fire.

6.- The SA validated on 08/14/2021 through record review of the City Fire Department's Report that on 7/26/21 at 1:53 AM the City Fire Department cleared the scene and departed the facility. The SA also validated through interview on 08/14/2021 at 10:54 AM with LPN#3 that the City Fire Department came to the facility on 07/26/2021 at approximately 1:30 AM and left the facility at approximately 1:53 AM on 07/26/2021.

7.- The SA validated on 08/14/2021 through record review that on 7/26/21 beginning at approximately 8:30 AM Director of Nursing, RN Supervisor #1, RN Supervisor #2, Assistant Director of Nursing (ADON), Medical Records, and Activity Director began resident room checks of the entire facility to ensure all lighters were removed. Room checks were completed and no lighters were found.

8.-The SA validated on 08/14/2021 through

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 610	Continued From page 42	F 610		

record review of the In-Services sign-in/attendance sheets, that on 7/26/21 beginning at approximately 10:30 AM Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, Licensed Nurses, housekeeping staff, business office staff, therapy staff, dietary staff, and administrative staff on Abuse and Neglect Prohibition Policy and Flammable materials and storage.

9.- The SA validated through interview, and record review of the QA Meeting ' s sign-in/attendance sheet dated 07/28/2021, and with the facility Administrator (ADM) interview on 08/14/2021 at 10:00 AM that on 7/28/21 at 12:30 PM, the Medical Director, Administrator, Director Assistant Director of Nursing, Social Services, Nurse Practitioner, Activity Director Business Office Manager, Wound Care Nurse and Medical Records held Quality Assurance Performance Improvement Committee meeting where the file was discussed and Resident Safety.

10.-On 08/14/2021 the SA validated through record review that on 8/10/21 at approximately 12:30 PM the facility's Psychiatric Nurse Practitioner assessed Resident #1 for psychosocial, emotional, and mental distress along with a review of all of Resident #1 current medications. Psychiatric Nurse Practitioner recommended a medication addition to assist with anxiousness- Resident #1 declined medication.

11.-The SA validated on 08/14/2021 through record review that the IJ Templates were provided to the facility on 8/10/21 at 4:02 PM the SA validated through record review, that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 610	Continued From page 43	F 610		

notification of the IJ was provided to the facility Administrator, Director Nursing and Assistant Director of Nursing. The validation on 08/14/2021 by record review documented that the Immediate Jeopardy (IJ) with Substandard Quality of Care was provided in writing, to the facility, per the submission of the IJ Templates dated 08/10/2021 at 4:02 PM.

12.-On 08/14/2021 the SA validated through record review that on 8/10/21 at approximately 5:15 PM Director of Nursing, RN Supervisor #1, RN Supervisor #2, RN Supervisor #3, Assistant Director of Nursing (ADON), Medical Records, Business Office Manager, Assistant Business Office Manager, Admission Coordinator, Maintenance Director, and Activity Director began resident room cheeks to ensure that all lighters were removed. Room checks were completed, and no lighters were found. Room checks completed at approximately 6:00 PM on 8/10/21 of all rooms in the building.

13.-The SA validated on 08/14/2021 at 10:00 A.M. through interview with the facility ADM that on 8/10/21 at 7:09 PM the facility Administrator initiated automated phone reporting system alert to resident families and staff of combustible safety storage, including facility storage of lighters, asking families not to purchase flammable materials including new policy implementation of combustible safety to use in conjunction with the current fire prevention policy. This combustible safety policy was created by the Quality Assurance Performance Improvement committee and approved by the facility medical director. The system automatically sends alerts and contacts families and staff listed in resident's records and payroll system.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 610	Continued From page 44	F 610		

14.- On 08/14/2021 the SA validated through a record review, the In-Service sign-in/attendance sheets dated 8/10/21, that beginning at 8:15 PM the Staff Development Coordinator initiated education on Combustible Safety storage and fire prevention with staff and residents to include Certified Nursing Assistants, Licensed nurses, housekeeping staff, Business Office staff, Therapy staff, Dietary staff, and administrative staff on new Combustible Safety Policy. No staff will be allowed to work without completing.

15.-On 08/14/2021 a record review validated that on 8/10/21 at 9:00 PM the facility notified the Mississippi State Department of Health of the 07/26/2021 fire event and of the pending Life Safety written notification.

16.- The SA validated through record review that on 08/14/2021 that on 8/11/21 at 10:30 AM Mississippi State Department of Life Safety notified of fire with unusual incident report submitted.

17.- The SA validated on 08/14/2021 through record review of the QA sign-in/attendance sheet and policy review that on 8/11/21 at 10:45 A.M. Medical Director. Administrator, Director of Nursing, RN Supervisor and LPN #4 held Quality Assurance Performance Improvement Meeting to include notification of Immediate Jeopardy to review steps initiated to prevent any further occurrence including new policy on Combustible Safety Storage. Policy includes no flammable materials in Resident's possession regardless of smoking status.

18.- The SA validated through record review on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 610	Continued From page 45	F 610		

08/14/2021 that on 8/11/21 at 9:30 A.M. the Resident Council Meeting was held with the Activity Director, Activity Assistant, Admission Coordinator, Resident Council President, and 13 total residents were present to discuss the new policy on Combustible Safety to include facility storage of flammable materials regardless of smoking status.

19.-The SA validated, through record review of the IJ Templates, on 08/14/2021, that on 8/11/21 at 5:30 PM the Mississippi State Department of Health added 3 additional Immediate Jeopardy's (IJ). The additional IJ's were provided to the facility per the written IJ Templates for F610; F656; and F742.

20.- The SA Validated through record review on 08/14/2021, that on 08/11/21 at 6:00 PM Resident #1 had a Smoking evaluation completed by the Director of Nursing (DON) and was deemed as a non-smoker. This was the second smoking evaluation completed on Resident #1 since admission which was on 6/29/21.

21.-On 08/14/2021 at 11:50 P.M. the SA validated through an interview with the Social Services Director (SSD) and through record review of the care plan for Res #1, that on 8/11/2021 at 6:45 PM the Social Services Director (SSD) developed a Plan of Care based on Resident #1's hallucinations that occurred on 7/26/21.

22.-The SA validated through record review on 08/14/2021 that on 08/11/2021 at 7:15 PM Psychosocial interviews were completed by Administrator #2 and Area Director of Business Development (ADBD)on eight (8) Residents with BIMS (Brief Interview Mental Status) of 13 or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 610	Continued From page 46	F 610		

higher in the seven (7) surrounding rooms to Resident to assess for psychosocial, emotional. or mental distress surrounding fire event with no emotional concerns noted.

23.- The SA validated through record review on 08/14/2021 that on 8/11/2021 at 7:19 PM a body audit was completed on Resident #1 by the MDS (Minimum Data Set) Coordinator to assess for any injuries with no negative findings.

24.- The SA validated through record review and through interview on 08/14/2021 at 10:00 A.M. with the facility ADM that on 08/11/2021 at 7:30 P-M. the Administrator and Director of Nursing received education on proper Abuse and Neglect Reporting and investigation guidelines following State and Federal Regulations by Senior Administrator from a sister facility.

25.- The SA validated on 08/14/2021 through record review of the QA sign-in/attendance sheets that on 08/11/2021 at 8:40 P.M. Medical Director. Administrator, Director of Nursing, Corporate Clinical Specialist (CCS) and Area Director of Business Development (ADBD) held an Ad-Hoc Quality Assurance Performance Improvement Meeting to include notification of additional Immediate Jeopardy (IJ) tags F610, F656 and F742 with no further recommendations.

26.- On 08/14/2021 from 10:54 A.M.-12:05 P.M. the SA interviewed seven (7) CNA's; two (2) RN's; Two (2) dietary workers; two(2) office staff; two (2) house keeping staff; four (4) LPN's; two (2) Social Workers; the facility ADM and the DON, to validate that all staff working on 8/11/2021 at approximately 9:30 P.M. were in-serviced and validated that in-services were initiated to include

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 610	Continued From page 47 Care Plans with a focus on behaviors and investigations of unusual occurrences. The SA validated through interview and record review on 08/14/2021 with the ADM and DON, that no staff members will be able to work until they are in-serviced. 27.-The SA validated on 08/14/2021 from 10:00 A.M. through 12:25 PM via observations, record reviews, staff interviews, and policy and procedure reviews that the facility submitted a Removal Plan for the IJ. The SA validated through record reviews, staff interviews, observations, and policy and procedure reviews, that the facility had completed all the tasks outlined in the Removal Plan on 08/11/2021 and the IJ 's were removed on 08/12/2021. On 08/14/2021 the State Agency (SA) validated, through interviews, record reviews, observations and policy and procedure reviews, that all corrective actions to remove the IJ, were completed on 08/11/2021 and the IJ was removed on 08/12/2021.	F 610		
F 656 SS=J	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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 -	F 656		9/13/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 48 (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 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. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, resident interviews, and policy and procedure reviews, the facility failed to develop and implement and/or revise a Comprehensive Plan of Care for one (1) of seven (7) residents reviewed for care plans. Resident #1 was not care planned for behaviors, delusions, and/or hallucinations following a fire that he set when he	F 656	1. On 07/26/21 at approximately 1:30 A.M. LPN #2 called 911 while facility alarm was sounding. Sprinkler systems were not activated as fire induced levels did not reach needed levels to activate. On 7/26/21 at approximately 1:33 A.M. Resident #1 was assessed by LPN #1 and found to have no injuries. The facility has	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 49	F 656		

set bed linens on fire and threw them into the hallway outside his room.

The facility's failed to adequately assess and develop a plan of care to reflect Resident #1's psychosocial well-being and failed to supervise Resident #1 during his admission adjustment to the facility. The facility's failure to prevent the potential for accidents and hazards resulted in Resident #1 setting his bed linens on fire and throwing them out into the hallway causing a fire that set off the fire alarms and caused the Fire Department to be dispatched to the facility in the early morning hours of 1:30 AM on 07/26/2021. This placed this resident and other residents at risk, in a situation that was likely to cause serious harm, injury, impairment or death.

The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 07/26/2021 when the facility's failure to provide supervision of Resident #1 as he obtained a cigarette lighter in his room and lit his bed linen on fire and threw the burning bed linens out into the hallway of the facility. On 08/11/2021 at 5:30 PM, the State Agency (SA) notified the facility Administrator of the IJ and SQC and the facility was presented with the IJ template.

The facility submitted a credible Removal Plan on 08/12/2021 at 5:29 PM in which the facility alleged all corrective actions to remove the IJ were completed on 08/11/2021 and the IJ removed as of 08/12/2021.

The SA validated the Removal Plan on 08/14/2021 and determined the IJ was removed prior to exit. Therefore, the scope and severity

no outside legal representative for Resident #1. Resident #1 is his own responsible party. On 7/26/21 at 1:39 A.M. Yazoo City Fire Department arrived on scene. On 7/26/21 at 1:43 A.M. LPN#2 contacted Administrator and Director of Nursing via text message. On 7/26/21 at 1:50 A. M. Administrator contacted facility. On 7/26/21 at 1:53 A.M. Yazoo City Fire Department cleared the scene and departed the facility. On 7/26/21 beginning at approximately 8:30 A.M. Director of Nursing, RN Supervisor #1, RN Supervisor #2, Assistant Director of Nursing (ADON), Medical Records, and Activity Director began resident room checks of the entire facility to ensure all lighters were removed. Room checks were completed, and no lighters were found. On 7/26/21 beginning at approximately 10:30 A.M. Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, Licensed Nurses, housekeeping staff, business office staff, therapy staff, dietary staff, and administrative staff on Abuse and Neglect Prohibition Policy and Flammable materials and storage. On 7/28/21 at 12:30 P.M., the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Social Services, Nurse Practitioner, Activity Director Business Office Manager, Wound Care Nurse and Medical Records held Quality Assurance Performance Improvement Committee meeting where the fire was discussed and Resident Safety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 50 for 42 CRF 483.21(b)(1) Comprehensive Care Plans (F656) was lowered from a "J" level scope and severity to a "D" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Finding include: Record review of the facility policy "Care Plans, Comprehensive Person-Centered" dated 2001 Revised December 2016 revealed "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. Policy Interpretation and Implementation ...8. The comprehensive, person - centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being... d. Describe any specialized services to be provided as a result of PASARR recommendations; e. Include the resident's stated goals upon admission and desired outcomes; f. Include the resident's stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such a desire... 9. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan ... 12. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS). 13.	F 656	2. All residents have the potential to be affected. 3. From 8/11/21 going forward all new admissions will receive an admission adjustment psychosocial care plan for the first quarter of their stay at the facility and ongoing as changes arise. On 8/12/21, the Staff Development Coordinator began education with nursing, administrative, housekeeping, dietary, and contract staff regarding requirements of each resident having psychosocial care plans developed as needed to meet psychosocial needs. 4. Beginning 8/16/21 an audit will be conducted weekly for four (4) weeks and then monthly for three(3) months by the Social Services Director to review completion and accuracy of the admission adjustment psychosocial care plan for three (3) new admissions. A report beginning on 8/18/21 will be submitted to the Quality Assurance Performance Improvement committee monthly for four (4) months by the Social Services Director for review and further recommendations. The Director of Nursing is responsible for monitoring 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 _____	C 08/14/2021

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 51	F 656		

Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change."

Record review of the facility policy "Behavioral Health Services" dated 7/22/2018 revealed, "Each resident must receive, and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Providing behavioral health care and services is an integral part of the person-centered environment. This involves an interdisciplinary approach to care, with qualified staff who demonstrate the competencies and skills necessary to provide appropriate services to the resident. Individualized approaches to care (including direct care and activities) are provided as part of a supportive physical, mental, and psychosocial environment, and are directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities..."

Record review of Res #1's "Admission Record" revealed that he had been admitted to the facility on 6/29/21 with admission diagnoses that included but were not limited to Secondary Malignant Neoplasm of other specified sites, Malignant Neoplasm of Pancreas ,Secondary Malignant Neoplasm of Liver and Intrahepatic Bile Duct, Secondary Malignant Neoplasm of Skin, Secondary and Unspecified Malignant Neoplasm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 52	F 656		

of Intra-Abdominal Lymph Nodes, Pain Unspecified, Abnormal weight Loss, Personal History of Urinary (Tract) Infections

Record review of Resident #1 ' s Baseline Care Plan v1.1 dated 6/29/21 revealed "A. Health Conditions/Special Treatments ...B.2. Cognitive status-Cognitively intact ...H. Safety Risk5. Does the resident smoke-b. Yes-Unsupervised."

Progress note dated 7/9/21 at 11:19 AM revealed copy of baseline care plan and orders given to Resident. The entry was signed by RN #6/Minimum Data Set (MDS) Coordinator.

Interview on 08/10/2021 at 7:38 AM, with Resident #1 (Res #1) revealed Res #1 stated that he was "having one of those bad days." He stated, "I really don't know what happened." Res #1 stated that he really believed that he was on too much medicine and that being over medicated caused him to set the fire. Res #1 stated that he had a lighter that he had brought to the facility in his bag upon admission. Res #1 stated that he had been admitted to the facility about a month when he set the fire. Res #1 stated that he used to smoke but "I don't smoke anymore." Res #1 confirmed that he set the fire with his lighter that he had in his room. Res #1 stated that he felt bad most of the time and was in a lot of pain. Res #1 stated that he really did not know what he set on fire or where he got it from "but I threw it out into the hallway." Res #1 stated that the fire department did come to the unit for the fire. Res #1 stated that the fire alarm was sounded when he threw the fire out in to the hallway. Res #1 stated that he knew now that he was not supposed to have a lighter in his possession. Res #1 stated that the fire had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 53	F 656		

burned the floor tiles in front of his bedroom. Res #1 denied any injury from the fire. "I was ok, I did not get hurt.". Res #1 stated that he had not visited with a doctor since the fire and had not left the facility. Res #1 stated, "I didn't get hurt. I don't know what made me do it. It was one of those bad days. I started hollering ' fire' and the staff came and got it out."

Interview on 08/10/2021 at 9:06 AM, with the two (2) facility Social Services (SS) staff the Director of SS (DSS) and Assistant Director of SS (ADSS) stated that she was made aware of a fire being set by Res #1 on 07/26/2021. Both the SS's confirmed that they did not update and/or revise Res #1's Plan of Care after the fire on 07/26/2021. The SS's have no knowledge of any assessments/evaluations that were done for Resident #1 immediately following the fire on 07/26/2021.

Interview on 08/11/2021 at 11:21 AM, with the two (2) Social Workers (SSD) and (ASSD) revealed that they had not updated the care plan of Resident #1 following the fire. SSD stated that she had not completed a care plan to address the behavioral and mental health needs of Res #1. SSD stated that she had not made referrals for services such as hospice, behavioral and mental health assessments, and services. SSD stated that neither of the Social Workers had documented their conversations and/or observations of Resident #1. SSD stated that the progress notes for Resident #1 have not been updated following the fire.

Interview on 08/12/2021 at 12:40 PM, with LPN#2, night shift nurse on second floor confirmed that she was a witness to the fire set

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 54	F 656		

by Res #1 on 07/26/2021. LPN#2 stated that she was working the night of the fire and it was her first night back to the facility since Res #1 had been admitted to the facility. This was the first time that she had worked with Res #1 and did not know much about him. LPN#2 did not update or revise Res #1's plan of care following the fire of 07/26/2021.

Record review of Res #1's medical records revealed there were no mental health assessments conducted for Res #1 following the fire of 07/26/2021. The record review revealed that the psychiatric nurse practitioner had not re-assessed Res #1 and there were no care plans to address Res #1's fire starting on 07/26/2021, and no care plans were observed in the medical records for behavioral health and mental health services discussed with Res #1. The Social Worker conducted a Brief Interview of Mental Status (BIMS) on 07/26/2021 and lowered his BIMS score one (1) point, from BIMS of 13, to BIMS of 12 which indicated "mild cognitive impairment." No mood changes noted with the BIMS score. The record review revealed no revision in the care plan of Res #1. There was no documentation in the medical records of Res #1 that documented the reason why the Social Worker Director (SSD) had completed the BIMS for Res #1 on 07/26/2021.

Record review of the Progress Notes for Res #1 since his admission of 06/29/2021 contained no information of his mental or behavioral assessments and/or monitoring of behaviors.

REMOVAL PLAN

The facility submitted a Removal Plan for the IJ.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 55	F 656		

Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ:

Brief Summary of Events

On 7//26/21 at approximately 1:30 am Licensed Practical Nurse LPN#1 reported witnessing a small fire and heard fire alarm sounding simultaneously. Fire was located in middle of second floor A wing hall outside of Resident #1's room (210). Fire was located in center hall not encountering outside walls. LPN (Licensed Practical Nurse) #1 immediately extinguished fire by smothering with a blanket. LPN #! inspected area surrounding previous fire for any further active fires with none found. LP #2 contacted local fire department. LPN #1 and LPN #3 were going room to room with in location of the incident and reported Resident #1 was up sitting on edge of the bed upon entering the room. LPN #1 questioned Resident #1 on awareness of fire starting. Resident #1 reported he lit the fire because he was cold but when he started to get hot, he threw it out the room. Resident #1 was immediately assessed by LPN #1 for any injury with no injuries found. Resident#1 reported he was in possession of a lighter. Lighter was removed by LPN #1. After room search completed, a second lighter was removed by LPN #3. Resident #1 denied any pain. Resident #1 refused to answer on where he obtained the lighter from. Resident #1 reported he had lighter to keep him warm. No other Residents were in surrounding incident. Resident #1 had no roommate.

Corrective Actions

1- On 07/26/21 at approximately 1:30 A.M. LPN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 56	F 656		

#2 called 91 1 while facility alarm was sounding. Sprinkler systems were not activated as fire induced levels did not reach needed levels to activate.

2 -On 7/26/21 at approximately 1:33 A.M. Resident #1 was assessed by LPN #1 and found to have no injuries. The facility has no outside legal representative for Resident #1. Resident #1 is his own Responsible Party.

3- On 7/26/21 at 1:39 A.M. Yazoo City File Department arrived on scene.

4.- On 7/26/21 at 1:43 A-M. LPN#2 contacted Administrator and Director of Nursing via text message.

5.- On 7/26/21 at 1:50 A. M. Administrator contacted facility.

6.- On 7/26/21 at l A.M. Yazoo City Fire Department cleared the scene and departed the facility.

7.- On 7/26/21 beginning at approximately 8:30 A.M. Director of Nursing, RN Supervisor #1, RN Supervisor #2, Assistant Director of Nursing (ADON), Medical Records, and Activity Director began resident room checks of the entire facility to ensure all lighters were removed. Room checks were completed and no lighters were found.

8.- On 7/26/21 beginning at approximately 10:30 A.M. Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, Licensed Nurses, housekeeping staff, business office staff, therapy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 57	F 656		

staff, dietary staff, and administrative staff on Abuse and Neglect Prohibition Policy and Flammable materials and storage.

9.- On 7/28/21 at 12:30 P.M., the Medical Director, Administrator, Director Assistant Director of Nursing, Social Services, Nurse Practitioner, Activity Director Business Office Manager, Wound Care Nurse and Medical Records held Quality Assurance Performance Improvement Committee meeting where the file was discussed and Resident Safety.

10.- On 8/10/21 at approximately 12:30 P.M. Psychiatric Nurse Practitioner #1 assessed Resident #1 fi)r psychosocial, emotional, and mental distress along with a review of all of Resident #1 current medications. Psychiatric Nurse Practitioner #1 recommended a medication addition to assist with anxiousness- Resident #1 declined medication

11.- On 8/10/21 at 4:02 P.M. State Agency (SA) notified facility Administrator, Director Nursing and Assistant Director of Nursing of Immediate Jeopardy (IJ) with substandard quality of care. State Agency Surveyor provided the facility with the Immediate Jeopardy (IJ) templates.

12.- On 8/10/21 at approximately 5:15 P.M. Director of Nursing, RN Supervisor #1, RN Supervisor #2, RN Supervisor #3, Assistant Director of Nursing (ADON), Medical Records, Business Office Manager, Assistant Business Office Manager, Admission Coordinator, Maintenance Director, and Activity Director began resident room cheeks to ensure that all lighters were removed. Room checks were completed, and no lighters were found. Room checks

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 58	F 656		

completed at approximately 6:00 P.M. on 8/10/21 of all rooms in the building.

13.- On 8/10/21 at 7:09 P.M. facility Administrator initiated automated phone reporting system alert to resident families and staff of combustible safety storage, including facility storage of lighters, asking families not to purchase flammable materials including new policy implementation of combustible safety to use in conjunction with the current fire prevention policy. This combustible safety policy was created by the Quality Assurance Performance Improvement committee and approved by the facility medical director. The system automatically sends alerts and contacts families and staff listed in resident's records and payroll system.

14.- On 8/10/21 beginning at 8:15 P.M. Staff Development Coordinator initiated education on Combustible Safety storage and fire prevention with staff and residents to include Certified Nursing Assistants, Licensed nurses, housekeeping staff, Business Office staff, Therapy staff, Dietary staff, and administrative staff on new Combustible Safety Policy. No staff will be allowed to work without completing.

15.- On 8/10/21 at 9:00 P.M. Mississippi State Department of Health notified of event and pending Life Safety notification.

16.- On 8/1 1/21 at 10:30 A.M Mississippi State Department of Life Safety notified of fire with unusual incident report submitted.

17.- On 8/11/21 at 10:45 A.M. Medical Director, Administrator, Director of Nursing, RN Superviseor and RN Supervisor #4, LPN #4 held

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 59	F 656		

Quality Assurance Performance Improvement Meeting to include notification of Immediate Jeopardy to review steps initiated to prevent any further occurrence including new policy on Combustible Safety Storage. Policy includes no flammable materials in Resident's possession regardless of smoking status.

18.- On 8/11/21 at 9:30 A.M. Resident Council Meeting Held with Activity Director, Activity Assistant, Admission Coordinator, Resident Council President, and 13 total residents were present to discuss the new policy on Combustible Safety to include facility storage of flammable materials regardless of smoking status.

19.- On 8/11/21 at 5:30 P.M. Mississippi State Department of Health added 3 additional Immediate Jeopardy's (IJ).

20.- On 08/11/21 at 6:00 P.M. Resident had a Smoking evaluation completed by Director of Nursing (DON) and deemed currently as non-smoker. This is second smoking evaluation completed on Resident since admission which was on 6/29/21.

21.- On 8/11/2021 at 6:45 P.M. Social Services Director (SSD) developed a plan of care based on Resident #1 hallucinations occurring on 7/26/21. Adjustments to be made to the plan of care in event of further behaviors on an as needed basis.

22.- On 08/11/2021 at 7:15 P.M. Psychosocial interviews were completed by Administrator #2 and Area Director of Business Development (ADBD)on eight (8) Residents with BIMS (Brief Interview Mental Status) of 13 or higher in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 60	F 656		

seven (7) surrounding rooms to Resident to assess for psychosocial, emotional. or mental distress surrounding fire event with no emotional concerns noted.

23.- On 8/11/2021 at 7:19 P.M. a body audit was completed on Resident #1 by the MDS (Minimum Data Set) Coordinator to assess for any injuries with no negative findings.

24.- On 08/1 1/2021 at 7:30 P-M. the Administrator and Director of Nursing received education on proper Abuse and Neglect Reporting and investigation guidelines following State and Federal Regulations by Senior Administrator from a sister facility.

25.- On 08/11/2021 at 8:40 P.M. Medical Director. Administrator, Director of Nursing, Corporate Clinical Specialist (CCS) and Area Director of Business Development (ADBD)held an Ad-Hoc Quality Assurance Performance Improvement Meeting to include notification of additional Immediate Jeopardy (IJ) tags F610, F656 and F742 with no further recommendations.

26.- On 8/11/2021 at approximately 9:30 P.M. in-services were initiated to include Care Plans with a focus on behaviors and investigations of unusual occurrences. No staff members will be able to work until they are in-serviced.

27.- Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of 08/11/21, and the Immediate Jeopardy was removed 08/12/21.

On Saturday August 14, 2021 the State Agency (SA) validated the facility's Removal Plan for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 61	F 656		

Immediate Jeopardy (IJ). Validations of the facility's Removal Plan was conducted through staff interview, observations, policy and procedure review, and record reviews. The SA's validations on 08/14/2021 revealed that the facility took the following actions to remove the IJ:

1-The SA validated through interview with LPN#3 on 08/14/2021 at 10:54 AM that on 07/26/21 at approximately 1:30 AM the facility fire alarm was sounding and the facility sprinkler systems were not activated as fire induced levels did not reach needed levels to activate the sprinkler system. LPN#3 validated that she called the Maintenance Director on 07/26/2021 at approximately 2:00 AM to obtain instructions as to how to reset the fire alarm after the fire had been extinguished by the facility staff.

2 -The SA validated through interview on 08/14/2021 at 10:54 AM with LPN#3, that she and LPN#1 had verbally assessed resident #1 on 7/26/21 at approximately 1:33 AM Resident #1 was verbally assessed by LPN #1 and found to have no injuries. The facility has no outside legal representative for Resident #1. Resident #1 is his own Responsible Party.

3- On 08/14/2021 at 9:00 AM the SA validated through record review of the City Fire Department's written report, that on 7/26/21 at 1:39 AM the City File Department arrived on the scene at the facility and the facility ' s fire alarm was sounding. Record review of the written City Fire Report validated that the fire was extinguished prior to their arrival at the facility.

4.- The SA validated through interview on 08/14/2021 at 10:54 AM with LPN#3 that on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 62	F 656		

7/26/21 at approximately 1:43 AM. LPN#3 had contacted the Administrator and Director of Nursing via text message that there had been a fire at the facility on 07/26/2021.

5.-The SA validated through interview on 08/14/2021 at 10:54 AM with LPN#3 that on 7/26/21 at 1:50 AM the Administrator contacted LPN#3 concerning the fire.

6.- The SA validated on 08/14/2021 through record review of the City Fire Department's Report that on 7/26/21 at 1:53 AM the City Fire Department cleared the scene and departed the facility. The SA also validated through interview on 08/14/2021 at 10:54 AM with LPN#3 that the City Fire Department came to the facility on 07/26/2021 at approximately 1:30 AM and left the facility at approximately 1:53 AM on 07/26/2021.

7.- The SA validated on 08/14/2021 through record review that on 7/26/21 beginning at approximately 8:30 AM Director of Nursing, RN Supervisor #1, RN Supervisor #2, Assistant Director of Nursing (ADON), Medical Records, and Activity Director began resident room checks of the entire facility to ensure all lighters were removed. Room checks were completed and no lighters were found.

8.-The SA validated on 08/14/2021 through record review of the In-Services sign-in/attendance sheets, that on 7/26/21 beginning at approximately 10:30 AM Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, Licensed Nurses, housekeeping staff, business office staff, therapy staff, dietary staff, and administrative staff on Abuse and Neglect

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 63	F 656		

Prohibition Policy and Flammable materials and storage.

9.- The SA validated through interview, and record review of the QA Meeting ' s sign-in/attendance sheet dated 07/28/2021, and with the facility Administrator (ADM) interview on 08/14/2021 at 10:00 AM that on 7/28/21 at 12:30 PM, the Medical Director, Administrator, Director Assistant Director of Nursing, Social Services, Nurse Practitioner, Activity Director Business Office Manager, Wound Care Nurse and Medical Records held Quality Assurance Performance Improvement Committee meeting where the file was discussed and Resident Safety.

10.-On 08/14/2021 the SA validated through record review that on 8/10/21 at approximately 12:30 PM the facility's Psychiatric Nurse Practitioner assessed Resident #1 for psychosocial, emotional, and mental distress along with a review of all of Resident #1 current medications. Psychiatric Nurse Practitioner recommended a medication addition to assist with anxiousness- Resident #1 declined medication.

11.-The SA validated on 08/14/2021 through record review that the IJ Templates were provided to the facility on 8/10/21 at 4:02 PM the SA validated through record review, that the notification of the IJ was provided to the facility Administrator, Director Nursing and Assistant Director of Nursing. The validation on 08/14/2021 by record review documented that the Immediate Jeopardy (IJ) with Substandard Quality of Care was provided in writing, to the facility, per the submission of the IJ Templates dated 08/10/2021 at 4:02 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 64	F 656		

12.-On 08/14/2021 the SA validated through record review that on 8/10/21 at approximately 5:15 PM Director of Nursing, RN Supervisor #1, RN Supervisor #2, RN Supervisor #3, Assistant Director of Nursing (ADON), Medical Records, Business Office Manager, Assistant Business Office Manager, Admission Coordinator, Maintenance Director, and Activity Director began resident room cheeks to ensure that all lighters were removed. Room checks were completed, and no lighters were found. Room checks completed at approximately 6:00 PM on 8/10/21 of all rooms in the building.

13.-The SA validated on 08/14/2021 at 10:00 A.M. through interview with the facility ADM that on 8/10/21 at 7:09 PM the facility Administrator initiated automated phone reporting system alert to resident families and staff of combustible safety storage, including facility storage of lighters, asking families not to purchase flammable materials including new policy implementation of combustible safety to use in conjunction with the current fire prevention policy. This combustible safety policy was created by the Quality Assurance Performance Improvement committee and approved by the facility medical director. The system automatically sends alerts and contacts families and staff listed in resident's records and payroll system.

14.- On 08/14/2021 the SA validated through a record review, the In-Service sign-in/attendance sheets dated 8/10/21, that beginning at 8:15 PM the Staff Development Coordinator initiated education on Combustible Safety storage and fire prevention with staff and residents to include Certified Nursing Assistants, Licensed nurses,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 65	F 656		

housekeeping staff, Business Office staff, Therapy staff, Dietary staff, and administrative staff on new Combustible Safety Policy. No staff will be allowed to work without completing.

15.-On 08/14/2021 a record review validated that on 8/10/21 at 9:00 PM the facility notified the Mississippi State Department of Health of the 07/26/2021 fire event and of the pending Life Safety written notification.

16.- The SA validated through record review that on 08/14/2021 that on 8/11/21 at 10:30 AM Mississippi State Department of Life Safety notified of fire with unusual incident report submitted.

17.- The SA validated on 08/14/2021 through record review of the QA sign-in/attendance sheet and policy review that on 8/11/21 at 10:45 A.M. Medical Director. Administrator, Director of Nursing, RN Supervisor and LPN #4 held Quality Assurance Performance Improvement Meeting to include notification of Immediate Jeopardy to review steps initiated to prevent any further occurrence including new policy on Combustible Safety Storage. Policy includes no flammable materials in Resident's possession regardless of smoking status.

18.- The SA validated through record review on 08/14/2021 that on 8/11/21 at 9:30 A.M. the Resident Council Meeting was held with the Activity Director, Activity Assistant, Admission Coordinator, Resident Council President, and 13 total residents were present to discuss the new policy on Combustible Safety to include facility storage of flammable materials regardless of smoking status.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 66	F 656		

19.-The SA validated, through record review of the IJ Templates, on 08/14/2021, that on 8/11/21 at 5:30 PM the Mississippi State Department of Health added 3 additional Immediate Jeopardy's (IJ). The additional IJ's were provided to the facility per the written IJ Templates for F610; F656; and F742.

20.- The SA Validated through record review on 08/14/2021, that on 08/11/21 at 6:00 PM Resident #1 had a Smoking evaluation completed by the Director of Nursing (DON) and was deemed as a non-smoker. This was the second smoking evaluation completed on Resident #1 since admission which was on 6/29/21.

21.-On 08/14/2021 at 11:50 P.M. the SA validated through an interview with the Social Services Director (SSD) and through record review of the care plan for Res #1, that on 8/11/2021 at 6:45 PM the Social Services Director (SSD) developed a Plan of Care based on Resident #1's hallucinations that occurred on 7/26/21.

22.-The SA validated through record review on 08/14/2021 that on 08/11/2021 at 7:15 PM Psychosocial interviews were completed by Administrator #2 and Area Director of Business Development (ADBD)on eight (8) Residents with BIMS (Brief Interview Mental Status) of 13 or higher in the seven (7) surrounding rooms to Resident to assess for psychosocial, emotional. or mental distress surrounding fire event with no emotional concerns noted.

23.- The SA validated through record review on 08/14/2021 that on 8/11/2021 at 7:19 PM a body audit was completed on Resident #1 by the MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 67	F 656		

(Minimum Data Set) Coordinator to assess for any injuries with no negative findings.

24.- The SA validated through record review and through interview on 08/14/2021 at 10:00 A.M. with the facility ADM that on 08/11/2021 at 7:30 P-M. the Administrator and Director of Nursing received education on proper Abuse and Neglect Reporting and investigation guidelines following State and Federal Regulations by Senior Administrator from a sister facility.

25.- The SA validated on 08/14/2021 through record review of the QA sign-in/attendance sheets that on 08/11/2021 at 8:40 P.M. Medical Director. Administrator, Director of Nursing, Corporate Clinical Specialist (CCS) and Area Director of Business Development (ADBD) held an Ad-Hoc Quality Assurance Performance Improvement Meeting to include notification of additional Immediate Jeopardy (IJ) tags F610, F656 and F742 with no further recommendations.

26.- On 08/14/2021 from 10:54 A.M.-12:05 P.M. the SA interviewed seven (7) CNA's; two (2) RN's; Two (2) dietary workers; two(2) office staff; two (2) house keeping staff; four (4) LPN's; two (2) Social Workers; the facility ADM and the DON, to validate that all staff working on 8/11/2021 at approximately 9:30 P.M. were in-serviced and validated that in-services were initiated to include Care Plans with a focus on behaviors and investigations of unusual occurrences. The SA validated through interview and record review on 08/14/2021 with the ADM and DON, that no staff members will be able to work until they are in-serviced.

27.-The SA validated on 08/14/2021 from 10:00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 68 A.M. through 12:25 PM via observations, record reviews, staff interviews, and policy and procedure reviews that the facility submitted a Removal Plan for the IJ. The SA validated through record reviews, staff interviews, observations, and policy and procedure reviews, that the facility had completed all the tasks outlined in the Removal Plan on 08/11/2021 and the IJ 's were removed on 08/12/2021. On 08/14/2021 the State Agency (SA) validated, through interviews, record reviews, observations and policy and procedure reviews, that all corrective actions to remove the IJ, were completed on 08/11/2021 and the IJ was removed on 08/12/2021.	F 656		
F 689 SS=L	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff interviews, resident interviews, and policy and procedure reviews, the facility failed to provide supervision for Resident #1 when he lit his bed linens on fire with a cigarette lighter, threw the burning bed linen out into the hallway, and caused a facility fire on 07/26/2021. Resident #1 was one (1) of seven (7) residents reviewed for supervision to prevent the potential for	F 689	1. On 07/26/21 at approximately 1:30 A.M. LPN #2 called 911 while facility alarm was sounding. Sprinkler systems were not activated as fire induced levels did not reach needed levels to activate. On 7/26/21 at approximately 1:33 A.M. Resident #1 was assessed by LPN #1 and found to have no injuries. The facility has no outside legal representative for	9/13/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 69 accidents/hazards. The facility's failed to adequetely assess and develop a plan of care to reflect Resident #1's psychosocial well being and failed to supervise Resident #1 during his admission adjustment to the facility. The facility's failure to prevent the potential for accidents and hazards resulted in Resident #1 setting his bed linens on fire and throwing them out in to the hallway causing a fire that set off the fire alarms and caused the Fire Department to be dispatched to the facility in the early morning hours of 1:30 A.M. on 07/26/2021. This placed this resident and other residents at risk, in a situation that was likely to cause serious harm, injury, impairment or death. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 07/26/2021, when the facility's failure to provide supervision of Resident #1 as he obtained a cigarette lighter in his room and lit his bed linen on fire and threw the burning bed linens out in to the hallway of the facility. On 08/10/2021 at 4:02 PM, the State Agency (SA) notified the facility Administrator of the IJ and SQC and the facility was presented with the IJ template. The facility submitted a credible Removal Plan on 08/12/2021 at 5:29 P.M., in which the facility alleged all corrective actions to remove the IJ were completed on 08/11/2021 and the IJ removed as of 08/12/2021. The SA validated the Removal Plan on 08/14/2021 and determined the IJ was removed prior to exit. Therefore, the scope and severity for 42 CFR(s): 483.25(d)(1)	F 689	Resident #1. Resident #1 is his own responsible party. On 7/26/21 at 1:39 A.M. Yazoo City Fire Department arrived on scene. On 7/26/21 at 1:43 A.M. LPN#2 contacted Administrator and Director of Nursing via text message. On 7/26/21 at 1:50 A. M. Administrator contacted facility. On 7/26/21 at 1:53 A.M. Yazoo City Fire Department cleared the scene and departed the facility. On 7/26/21 beginning at approximately 8:30 A.M. Director of Nursing, RN Supervisor #1, RN Supervisor #2, Assistant Director of Nursing (ADON), Medical Records, and Activity Director began resident room checks of the entire facility to ensure all lighters were removed. Room checks were completed, and no lighters were found. On 7/26/21 beginning at approximately 10:30 A.M. Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, Licensed Nurses, housekeeping staff, business office staff, therapy staff, dietary staff, and administrative staff on Abuse and Neglect Prohibition Policy and Flammable materials and storage. On 7/28/21 at 12:30 P.M., the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Social Services, Nurse Practitioner, Activity Director Business Office Manager, Wound Care Nurse and Medical Records held Quality Assurance Performance Improvement Committee meeting where the fire was discussed and Resident Safety.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 70 (2)-Accidents/Supervision (F689) was lowered from "L" level scope and severity to a "F" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings: Record review of the facility policy and procedure titled: "Fire Plan Appendix I: Fire" page 150 (undated) was provided as the facility's policy and procedure for "Fire Prevention." The Fire Policy revealed, "Fire is a rapid oxidation process that releases energy in varying intensities in the form of heat and often light, generally creates and releases toxic vapors. Fire does not have to be in immediate proximity to be fatal. The reduced oxygen and production of smoke and fumes can release breathable air, creating an anaerobic environment that leads to asphyxiation. Not all fires create visible smoke. Inside a building where airflow is restricted, the risk of dying from oxygen starvation is greatly increased. If a fire is located at one end of the building, resident on the fire end will be evacuated to the other end of the building. If the fire is uncontrollable, all residents be evacuated outside through doors at either end of the hallway. Second floor residents will be brought downstairs at either end of the hallway and then evacuated out the side doors. After fire is discovered, nurse on that station is responsible for calling 911 and pulling fire alarm. If the fire is small and contained, fire extinguishers may be used. When evacuating room, staff must check all rooms for fire and remove all residents from rooms. When room is clear close all doors, including bathroom doors."	F 689	2. All residents have the potential to be affected. 3. On 8/10/21¿Staff Development Coordinator¿initiated¿education¿on Combustible Safety storage and fire prevention¿with nursing, administrative, housekeeping, dietary, and contract staff¿and¿current residents on new Combustible Safety Policy. 4. Beginning on 8/16/2021 the Admission Coordinator will¿monitor¿at least¿three Residents rooms weekly for four weeks and then five resident's rooms monthly for three months for¿compliance with combustible safety storage¿by facility policy. Any concerns will be immediately addressed by the Administrator or Director of Nursing for further intervention. A report beginning 8/18/21 will be¿submitted¿to the Quality Assurance Performance Improvement for review and recommendations monthly for four (4) months. The Administrator¿is responsible for¿monitoring 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 _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 71	F 689		

The facility policy and procedure titled, "Policy for Resident Incident and Visitor Accident Report", revised 7/23/18 and reviewed 10/08/2020 revealed, "The facility will conduct an investigation of all incidents involving residents of the facility...The investigation will be conducted by designated personnel and reported to the Administrator/designee... Procedure: Reporting of Resident Incidents and Visitor Accidents: Any employee witnessing or having knowledge of an incident or accident involving a resident or visitor must immediately report such occurrence to his/her supervisor... Regardless of how minor an incident/accident appears to be, it must be reported to the Department Supervisor, Administrator, or DON/designee. As soon as possible after becoming aware of an incident/accident, the Witness Form must be completed by any person witnessing the incident or any person thought to have witnessed the incident. An Incident Report must be completed by the person reporting the incident or the supervisor on the shift that the incident occurred. The Investigation must be initiated by the Department Supervisor or Charge Nurse and completed by the Administrator or DON/designee..."

Observation on 08/10/2021 at 6:15 AM, of Resident #1's room revealed that the floor in front of his doorway in the hall had an area of moderate size to be discolored with brown marks that would not rub off when surveyor rubbed the brown marks with her shoes. RN#4 stated that she was not sure of what the brown discoloration was on the floor in front of Resident #1's room. At that time a staff member identifying herself as Physical Therapy (PT) staff interrupted and said

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 72	F 689		

"those brown marks are from (Proper Name of Resident 1) throwing his burning bed linens out in to the hall. Those brown marks were not there prior to the fire." PT denied witnessing the fire. PT stated that the other staff had informed her about the fire and had shown her the brown marks to be where Res #1's burning bed linens were thrown.

Observation on 08/10/2021 at 6:30 AM, revealed that the "Annex" unit on the first floor of the facility housed numerous bedfast, oxygen dependent, and tracheostomy residents. The facility tour of the second floor of the facility revealed several bedfast residents and residents with oxygen.

Interview on 8/10/2021 at 6:54 AM,. with the Director of Nursing (DON) revealed that she had no knowledge of a fire at the facility in July 2021. The DON stated that she had been off some in July 2021 and possibly there had been a fire that she was not informed had occurred. The DON stated that she would go check her records to see if a fire was reported without her knowledge.

Interview 8/10/2021 at 7:20 AM, with the Activities Director (AD) revealed that she had been the AD for three (3) years. The AD stated that she had no knowledge of a fire being discussed in the facility "stand-up meeting" and the AD had not been questioned or interviewed by anyone about a second fire at the facility. She stated that she is responsible for keeping all the lighters, cigarettes, cigars, and smoking materials, for the residents at the facility that use them. The AD stated that since the fire at the facility in March 2021 she locks the smoking materials up in her office through the week and day hours and on weekends and after hours the nurses lock up the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 73	F 689		

smoking materials. Residents are not allowed to have lighters, matches, and/or smoking materials in their possession. Facility staff have to be outside in the smoking area with the residents during smoke breaks. AD stated that she had not attended any In-Services concerning the fire of July 2021. AD stated that there are 17 smokers in the facility and all 17 were evaluated for smoking safety. The AD stated that Res #1 is not a smoker. She stated that Res #1 was the resident that started a fire up on the second floor a couple of weeks prior. She stated that she participated in a "sweep" of the residents rooms to look for lighters, matches, smoking materials, and harmful items. If items were found they were to be taken to the nursing station.

Interview and Observation on 08/10/2021 at 7:35 AM with Certified Nursing Assistant (CNA#4) revealed that she had worked at the facility for 25 years. CNA #4 stated that she worked the 6:30 AM -2:30 PM first (1st) shift at the facility on the second floor. CNA #4 confirmed that the brown discolored "scorched" marks on the floor were not there until Res. #1 set the fire. CNA #4 stated that Res #1 would be able to tell surveyors about what had occurred and that he was very interviewable. CNA #4 had no knowledge of Res #1 having been placed on close observation or on regular rounds checks. CNA #4 has not been interviewed or questioned concerning Res #4's mental or physical health after the fire he set on 07/26/2021.

Interview and observation on 08/10/2021 at 7:38 AM, with Resident #1 stated that he was "having one of those bad days." He stated: "I really don't know what happened." He said that he really believed that he was on too much medicine and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 74	F 689		

that being over medicated caused him to set the fire. Res #1 stated that he had a lighter that he had brought to the facility in his bag upon admission. Res #1 stated that he had been admitted to the facility about a month when he set the fire. Res #1 stated that he use to smoke but "I don't smoke anymore" and confirmed that he set the fire with his lighter that he had in his room. Res #1 stated that he felt bad most of the time and was in a lot of pain. Res #1 stated that he really did not know what he set on fire or where he got it from "but I threw it out into the hallway." He stated that the fire department did come to the unit for the fire and that the fire alarm was sounded when he threw the fire out into the hallway. Res #1 stated that he knew now that he was not suppose to have a lighter in his possession. Res #1 stated that the fire had burned the floor tiles in front of his bedroom. He denied any injury from the fire and stated, "I was ok, I did not get hurt." During the interview, he had rapid disconnected speech. At times, when he was talking, he appeared to loose his concentration. At times, during the interview, Res #1 was difficult to understand. He rambled and mumbled in a soft "rapid" low voice. Res #1 stated that he had not visited with a doctor since the fire and had not left the facility. He stated, "I don't know what made me do it. It was one of those bad days. I started hollering 'fire' and the staff came and got it out."

Interviews on 08/10/2021 at 7:57 AM, with the facility Administrator (ADM) and the facility Director of Nursing (DON) revealed the DON stated that she had received a text message that there was a possible "paper" fire that the nurse had put out with a blanket. The ADM stated that the facility was not required to report small fires

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 75	F 689		

with no injuries and there was no abuse involved. The ADM stated the "small" fire did not cause any damage and was not reported. The ADM stated that there had not been an investigation completed because there was nothing to investigate, the nurse had put the fire out prior to the fire department's arrival and it was "very small." The ADM stated that the fire department was called but they did not have to do anything because the small fire was out when the fire department got to the facility. The ADM and DON stated that they were not sure of the exact date of the second fire but that it was 2-3 weeks prior to 08/10/2021. The ADM stated: "We will have to look at the text messages in our phones to get the date of the fire." The DON and ADM did not give any details or names involved with the "second floor" facility fire. ADM stated that the resident involved in the fire in July 2021 was not a smoker and that he was a new admission and should not have had a lighter.

Interviews on 08/10/2021 at 9:06 AM, with the Director of Social Services (DSS) and the Assistant Director of Social Services (ADSS) revealed the ADSS stated that she was made aware of a fire being set by Res #1 on 07/26/2021. The second floor first shift LPN#5 had called her on the morning after the fire and had asked her and the DSS to come to second floor to talk to Res #1 because he had set a fire on the night shift in the early morning hours and had been in possession of a cigarette lighter. The ADSS and the DSS stated that they were not sure of the date of when the fire was set by Res #1 but they thought it happened on July 26, 2021 at about 2:00 AM. Both stated that when they got to Resident #1's room they noticed that the floor outside his room was scarred as if it had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 76	F 689		

burned. They both went inside of Res #1's room and he told them that he was sitting in a car waiting on a friend to come out of the store and decided to light a cigarette. Res #1 said he noticed the fire and threw it in the hall. Res #1 stated that he threw the blanket in the hall, and yelled, "fire" and got back in the bed. Res #1 stated that he thought his medications were causing him to "act out." The ADSS stated that Res #1 asked for a medication decrease and that she did not know for sure but thought that he had a medication decrease 48 hours prior to the fire on 07/26/2021. Both stated that Res #1 was homeless prior to his admission to the local hospital, for "end stage cancer." Both stated that they have had monthly fire drills at the facility but there have been no in-services on fire prevention/safety since the fire on 07/26/2021 that was set by Res #1. They stated that they had never had a facility in-service on how to operate a fire extinguisher. The second floor LPN#5 and LPN#2 had told Social Services that Res #1 had told them that he set the fire because he was cold. Res #1 did not have a room mate on 07/26/2021. The facility did conduct a room audit of 100% of all resident rooms in the facility on Thursday (7/29/2021) after the fire. Both stated that they did not up date and/or revise Res #1's Plan of Care after the fire on 07/26/2021. The DSS and ADSS have no knowledge of any assessments/evaluations that were done for Res #1 immediately following the fire on 07/26/2021. Both were not aware of any investigations that were conducted after the fire of 07/26/2021.

Interview on 08/10/2021 at 10:49 A.M. with the SSD and ADSS revealed that they were told by the ADM on 07/26/2021 not to document the incident of the fire set by Res #1 in the computer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 77	F 689		

or in the Medical Record of Res #1. The ADM told them to make a written statement and to give it only to her to keep in her office in a "Hot File." They stated that they are totally an electronic charting system and there were no paper charts in the facility. The hand written statements that they made were given to the ADM to keep in her office. They stated that they do inventory lists for new admissions and that if Res #1 had a lighter in his possession upon admission that it should have been obtained and placed in a box at the nursing station for the resident upon discharge. They have no documentation that Res #1 had a lighter and they stated that Res #1 was not assessed as a smoker.

Observations on 08/10/2021 at 12:15 PM, of the number of rooms and the number of residents for "A wing" of second floor contained 13 rooms and 20 residents. The second floor of "B wing" had 14 rooms and 27 residents. The observation revealed that Resident #1's was located on the "A wing" of second floor.

Interview on 08/10/201 at 2:15 PM, LPN#7 stated that she was working the first shift on the B Wing 7:00 AM - 7:00 PM on the second floor the morning of 07/26/2021. LPN#5 was working the "A" wing of the second floor. "A" wing was the wing that housed Res #1. LPN#7 stated that when she got to work the night shift nurse LPN#2, was still at work and she relayed to the day shift what had happened with Res #1 setting a fire on the night shift during the early morning hours. LPN#7 stated that no one from the facility came to the unit to conduct an investigation of the events. LPN #7 stated that Res #1 was not acting like he usually did and he "seemed different." LPN#5 called the social worker and asked her to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 78	F 689		

come up and talk to Res #1. LPN#7 stated that she had no knowledge of a facility investigation.

Interview on 08/10/2021 at 2:22 PM, with LPN#5 stated that on 7/26/2021 she called the social worker, and asked her to come up and interview Res #1. She stated that he was not acting like he normally acted. LPN#5 thought he was pacing and walking about his room and appeared anxious. LPN#5 thought that Res #1 needed to be assessed. LPN#5 stated that Res #1 was on a lot of medication. LPN#5 had no knowledge of a facility investigation and she had not documented anything in the medical records of Res #1. LPN#5 did not have any conversation with the facility ADM or DON concerning Res #1. LPN#5 had no knowledge of Res #1 having been placed on rounds checks through the night and day and had no knowledge of Res #1 having been placed on close observation after the fire on 07/26/2021.

Interview on 08/10/2021 at 3:15 PM, with the city Fire Chief revealed that the report was signed by another fireman that had attended to the fire at the facility on 07/26/2021. Fire Chief stated that the fire alarm did sound and the fire department did come to the facility early in the morning just after midnight at approximately 1:39 AM on 07/26/2021. The alarm was sounding when they arrived at the facility and the fire had been put out by a nurse on the second floor of the facility. The Fire Chief stated that there were no injuries reported.

Record review of the State Fire Marshall form signed 07/26/2021 confirmed that the 911 call was dispatched through the 911 services. The 911 dispatch report was obtained and reviewed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 79	F 689		

The report documented the fire alarm dispatched the Fire Department at 1:31 AM and the Fire Department arrived at 1:39 AM. The fire was controlled at 1:53 AM and the unit was cleared at 1:53 AM. No other details were documented on the fire department report or the 911 dispatch report.

Record review of the CAD Detail revealed an incoming 911 call was received at 1:31 AM on 7/26/2021 from the facility.

Interviews on 08/10/2021 at 3:45 PM with LPN #7 and RN #2 revealed that the 24 hour report that was kept at the nursing station on second floor contained no reports of the fire set by Res #1 on 07/26/2021. No assessments or change in conditions documented in the 24 hour report for Res #1 on 07/26/2021. Both nurses stated that all changes in conditions, changes in mental status, changes in medications, and incidents/accidents were to be documented in the 24 hour report and maintained at the nursing station. Both nurses confirmed that the fire set by Res #1 should have been an event that was documented in the 24 hour report at the nursing station. Both nurses confirmed that there was no documentation on 07/25/2021, 07/26/2021, and 07/27/2021 contained in the 24 hour report concerning Res #1 and the fire he set on the second floor.

Record review of the 24 hour reports were obtained and reviewed and there was no fire documented on the 24 hour report for 7/25/2021-7/27/2021. The mental and physical condition of Res #1 was not documented in the 24 hour reports.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 80	F 689		

Interview on 08/10/2021 at 3:51 PM with the ADM and the DON confirmed that they had not investigated the fire set by Res #1 on 07/26/2021 and they had not reported the fire set by Res #1 to any State agencies. The ADM stated that she received a text message from the facility at approximately 2:00 AM on 07/26/2021 that Res #1 had set a small fire with a piece of paper. The ADM did not conduct an investigation and did not report the fire. ADM confirmed that she had not obtained any statements from Res #1 and had not updated and/or revised his plan of care or behavioral health assessments. ADM stated that it was her thoughts that Res #1 set the fire because he was use to setting fires due to his being homeless and living on the streets. ADM stated that the staff were verbally informed that a fire had occurred on 07/26/2021. ADM stated that she realized now that she had made a mistake by not reporting the fire of 07/26/2021 set by Res #1. ADM stated that they did not conduct a thorough investigation of the fire on 07/26/2021 and that they did not place Res #1 on close observation after the fire on 07/26/2021. ADM stated that resident #1 was not a smoker and they were not able to predict that a non-smoker would have a cigarette lighter.

Interview on 08/11/2021 at 10:25 AM the Maintenance Director/Supervisor (Main. Super.) revealed that he had been called "by someone at the facility" in the early morning hours of 07/26/2021, at approximately 3:00 AM. The Maintenance Supervisor (Main. Super) was unsure of the date of the fire and was unsure of the time he was contacted. He also stated that he did not know the name of the person that called him about the fire in the facility. He stated that he did not complete any reports concerning

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 81	F 689		

the fire and did not document his being contacted by the facility. He stated that he was asleep in his bed when he got the call and does not remember the details. Main. Super. stated that he was unable to go back to sleep because he was worried that the fire alarm may need re-setting so he got out of his bed and drove to the facility at approximately 3:00 AM to check on the fire alarm. Main. Super. stated that when he got to the facility he went to the fire alarm to check it and to make sure it was functioning properly. The fire alarm had been re-set prior to his arriving at the facility, but he does not know who re-set the fire alarm. He stated that he went to the second floor of the facility to see where the fire had been set and to look around the facility. He stated that there was a pile of what looked like a burned blanket or sheets in the floor out in the hallway in front of Res. #1's room. The Main. Super. stated that he really was not able to make out what the burned items were and he did not touch them. He stated that he did not ask any questions of anyone and he did not dispose of the burned items that were in the floor. Main. Super. stated that he was not asked by anyone to document his findings after coming to the facility, and he was not asked to investigate the fire or its cause. Main. Super. stated that he does not have any knowledge of how the fire was started and/or who started the fire. The Main. Super. stated that he has no idea how the fire was put out, or who put out the fire. The Main. Super. stated that he conducts the monthly facility fire drills and he has had the local fire department to come to the facility a couple of times per year to instruct the staff on the use of a fire extinguisher. He stated that only a fire extinguisher is to be used in putting out a fire at the facility. Main. Super. stated that he had no knowledge of any fire

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 82	F 689		

prevention In-Services and/or fire extinguisher use In-Services having been conducted in the facility following the fire in July 2021. Main. Super. stated that he checked all of the facility fire extinguishers in the building and none of them had been used in putting out the fire. The Main. Super. had no knowledge of an investigation by the facility following the fire in July 2021. Main. Super. stated that all the information that was given to him was that the fire department did arrive at the facility as a result of the fire alarm sounding. Main. Super. stated that the sprinkler system had not been engaged. Main. Super. stated that he had no contact with the City Fire Department following the fire and the Fire Department had left the facility prior to his arrival. The Main. Super. confirmed that the brown discolored marks on the floor in front of Res. #1's room was caused by the fire and were not present prior to the fire.

Interview on 08/11/2021 at 11:21 AM with the two (2) Social Workers, Social Services Direstor (SSD) and the Assistant Social Services Director (ASSD) revealed that they had not updated the care plan of Res #1 following the fire of 07/26/2021. SSD stated that she had not developed a care plan to address the behavioral and mental health needs of Res #1. SSD stated that neither of the Social Workers had documented their conversations and/or observations of Res #1. SSD stated that the Progress Notes for Res #1 have not been updated following the fire on 07/26/2021. SSD had no knowledge of a facility investigation that was conducted following the fire on 07/26/2021. SSD and ASSD both stated that Res #1 told them that he was in a car with another guy when he lit a cigarette and started the fire. Res #1 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 83	F 689		

delusional on 07/26/2021 and was unable to give a "sound" reason for starting the fire on 07/26/2021. SSD stated that there are no care plans addressing Res #1's delusional thoughts following the fire on 07/26/2021. SSD stated that Res #1 told them that he thought his medications needed adjusting. The SSD stated that there is no documentation available in Res #1's medical records to address his mental health and no care plan to address Res #1's medication adjustments.

During interviews on 08/11/2021 at 2:47 PM with the three (3) second shift Certified Nursing Assistants (CNA#6, CNA #8, CNA #9) who were assigned to the second floor, all three (3) CNA's confirmed that the brown discolored marks in the floor outside of Res. #1's room was caused by the fire set by Res #1 on 07/26/2021.

Observation on 08/11/2021 at 2:50 P.M. surveyor measured the brown discolored area in the hallway on the floor in front of Res. #1's room. The measurements were 31 inches long by 16 inches wide.

Interview on 08/12/2021 at 12:40 PM with LPN#2, the night shift nurse who was working on the A Wing 7/26/2021 when Resident #1 set the fire on the second floor. This was the first time that she had worked with Res #1 and did not know much about him. LPN#2 stated that she was at the nursing station with the other nurse (LPN#1) when they heard CNA#1 holler "FIRE" and they all ran down the "A" wing of second floor where they saw, CNA #1, trying to put out the fire burning in the floor outside of Res. #1's room. CNA #1 had a "chair pad" or a "brief" slapping at the fire which was applying more oxygen to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 84	F 689		

fire. LPN #1 told CNA #1 to "stop fanning the fire" and to let her take control. LPN #2 stated that the flames from the fire were approximately as high as a resident's bed would be in its lowest position. LPN #1 obtained a blanket from the nearby linen cart and threw it on top of the burning bed linens and LPN#1 danced on top of the blanket with her feet smothering the flames which put out the fire. LPN #1 told CNA #1 to "never fan a fire." "It all happened so fast none of us had time to grab a fire extinguisher." LPN#1 took control and put out the fire. The fire alarm did go off and the fire doors closed. The first floor LPN#3 arrived soon after the fire was out with her fire extinguisher from first floor. LPN #3 did not have to use the fire extinguisher. LPN #3 called the DON and the ADM and then came and told LPN#2 not to document the fire in the computer and not to document the fire on the 24 hour report like was usually done. LPN #3 went to Res #1's room and he gave her a cigarette lighter from his pocket and they got his permission to search his room for more lighters and LPN #3 found a second lighter in Res #1's bag. LPN#2 confirmed that they did not remove any residents from the building and they did not assess any residents after the fire. LPN #2 stated that they did not place Res #1 on a suicide watch nor did they place Res #1 on any safety rounds checks after he set the fire on 07/26/2021. LPN#2 stated that most all the residents on second floor slept through the entire fire and the fire alarm. The city fire department did arrive on the unit after LPN#1 had put the fire out and then they left. The fire department did not clean up the burned linens and they did not ask LPN#2 any questions. LPN #2 stated that she had no idea how the fire alarm was reset or who re-set the fire alarm. LPN#2 stated that Res #1 told them that he "just woke up

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 85	F 689		

and could not believe he had set the fire." Res #1 did not verbalize why he set the fire. He told the nurses that he was sitting in a car with some friends and decided to light a cigarette when he saw the fire. LPN #2 stated that Res #1 was quite and rather calm after the fire. LPN#2 asked Res #1 if he was hurt and he said "no." LPN#2 stated that LPN #1 cleaned up the burned debris and threw it away. LPN #2 stated that no body audits of any residents were documented following the fire on 07/26/2021. LPN #2 stated that the ADM nor the DON had spoken to her about the fire and no investigation had been conducted to her knowledge. LPN#2 stated that LPN #3 had told her to write a brief statement on a piece of plain paper and put it in an envelope and leave it at the nursing station for the DON to pick up the next morning. LPN #2 stated that she had not been spoken to about the fire since it happened on 07/26/2021 at 1:30 AM. LPN #2 stated that she was told by other staff on second floor that Res #1 was not acting like he usually acted and they had thought he was "not himself.", but because she had not worked with Res #1 prior to 07/26/2021 she had nothing to compare his actions too. LPN #2 stated that she stayed over until the morning shift and verbally reported what had happened with the fire to the morning staff, and she called the social worker to come up and talk to Res #1 because she thought he may need to have a talk with some staff that knew him better. The LPN#2 did not up date or revise Res #1's plan of care following the fire of 07/26/2021.

Observation on 08/12/2021 at 2:26 PM with the Maintenance Supervisor/Director, using his personal measuring tape, he measured the brown discolored scorched marks on the floor in front of room #210 on second floor. The Maint.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 86	F 689		

Super. stated that the measurements were 29 inches long and 18 inches wide. Maint. Super. confirmed that the brown discolored marks were caused by the fire on 07/26/2021.

Interview on 08/12/2021 at 4:18 PM with the psychiatric Nurse Practitioner (PNP), he confirmed that the facility had not notified him to assess Res #1 following the fire on 07/26/2021. He reported that he had no knowledge of the fire until 08/10/2021 after the surveyor entered the building to conduct an investigation. He stated that he would have usually been contacted after an event like setting a fire, but had not been contacted. PNP stated that he happened to be in the facility on 08/10/2021 when a staff member approached him and asked him to talk to Res #1 because he had set a fire on 07/26/2021 and the State was in the facility to investigate. PNP stated that he had not seen Res #1 since his admission assessment.

Interview on 08/12/2021 at 8:30 PM, with LPN#1, revealed that she had been the one that put the fire out on the unit. LPN#1 stated that she was sitting at the nursing station on second floor at about 1:30 AM on 07/26/2021, when they heard someone yell out "FIRE" and they took off running. LPN#1 stated that CNA #1 was fanning the fire with a "diaper" and the flames were rising up about three (3) feet high and that CNA #1 was making the fire worse by fanning it. LPN#1 told CNA #1 to stop fanning the fire and slapping the "diaper" at the fire and she asked her to step back and let her put it out. LPN #1 grabbed a blanket off the linen cart that was close by and folded it in half and dropped it on top of the fire and smothered it out. She told CNA #1 to never fan at a fire that it makes it worse. LPN #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 87	F 689		

stated that she was assigned to work "B" wing and that LPN #2 was assigned to work "A" wing of second floor. The fire was on the "A" wing in front of Res #1's room. LPN #1 stated that the fire alarm did sound and the fire doors did close but the sprinkler system did not activate. LPN #1 stated that there was a "fair amount of smoke" but not terrible. LPN #1 stated that the fire department came to the unit dressed in full fire gear. The Fire Department asked: "who put out this fire and played the "hero?" LPN #1 stated that the fire department took a statement from her and took her phone number and told her that she had "saved lives." LPN #1 stated that LPN #2 had talked to LPN #3 and was told by the ADM not to document the fire and to not put anything in the computer or in the 24 hour report book that the fire had occurred. LPN #1 stated that she had worked at the facility for years prior and had worked at State hospital for 17 years prior and that fires had to be well documented and statements taken from all involved, she had never been told, until 07/26/2021, to not document a fire. LPN #1 stated that she felt that it was wrong to not report the fire and/or to document the events of the fire, but she and LPN #2 did what they were instructed to do by LPN #3, who had talked to the ADM. LPN #1 stated that she and LPN #3 had gone in to talk to Res #1 immediately after the fire was put out on 07/26/2021 and he appeared "scared" and anxious. LPN #1 stated that he was not acting like he "normally" had and that he volunteered to give them the cigarette lighter from his pocket. She stated that they looked at Res #1's upper body to make sure he was not burned but he refused to let them look at his lower body. LPN#1 stated that there was no documentation generated for body audits completed and/or of any close observations or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 88	F 689		

rounds checks following the fire on 07/26/2021. LPN #1 stated that LPN #3 had found a second cigarette lighter in Res #1's room that he had inside of a purple "Crown Royal" draw string bag. LPN #1 stated that Res #1 did not realize what he had done and when the Fire Department came to the unit he was pacing and walking in his room and was anxious. Res #1 did not have a room mate at the time he set the fire. LPN #1 stated that Res #1 had taken the bed linens off of the extra empty bed in his room and had lit the bed linens on fire and threw them out into the hallway. Res #1 told LPN #1 that he was cold and was trying to get warm, so he set the bed linen on fire to get warm. Res #1 also told LPN #1 that he was sitting in a car with some friends and thought he was lighting a cigarette. LPN #1 stated that she asked the fire department if she could throw the burned linens and blanket away and they told her to go ahead and throw it away that there were no lingering sparks. LPN #1 stated that she cleaned the floor and threw the burned linen and blanket in the trash. LPN #1 stated that never did the ADM or the DON obtain a statement from her nor did they talk to her about the fire until the surveyors came to investigate on 08/10/2021. LPN #1 had no knowledge of a facility investigation concerning the fire prior to 08/10/2021. LPN #1 stated that one of the residents at the facility, (Res #7) was up and in his wheel chair rolling about the unit when he told CNA #1 that Res #1 had started the fire and that was when CNA #1 saw the fire. LPN#1 stated that Res #7 was a reliable witness and he was able to tell LPN #1 what he witnessed. LPN #1 stated that Res #7 had been on "A wing" rolling about in his wheel chair when he saw Res #1 light his bed linen on fire and throw them out in the hallway. Res #7 hollered fire first and got CNA #1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 89	F 689		

attention and then she hollered "fire." LPN #1 stated that (Res #7) had been discharged from the facility in August 2021. LPN #1 had no knowledge of Res #7 having been questioned by anyone following the fire of 07/26/2021. LPN #1 stated that to her knowledge Res #7 did not give a statement to the facility ADM concerning the fire set by Res #1. LPN #1 stated that Res #7 was the only witness that actually saw Res #1 light the fire. LPN #1 stated that she gave a written statement, for the first time, to the ADM on Tuesday morning 08/10/2021, after the surveyors entered the facility.

Interview on 08/14/2021 at 10:54 AM, with LPN #3 revealed that she had been the first floor LPN on 07/26/2021. LPN #3 stated that early in the morning of 07/26/2021 at approximately 1:30 AM the fire alarm went off and the fire doors closed. When the alarm went off LPN #3 began going room to room on first floor closing doors and checking area for fire. LPN #3 had no idea where the fire was located, so she took the fire extinguisher and started checking all areas for the fire. LPN #3 stated that the "security system" called the facility and reported to her exactly where the fire was on "A wing" of the second floor. When LPN #3 received the location of the fire from the "fire/security system" she went up the stairs to second floor with the fire extinguisher. LPN #3 stated that when she arrived on second floor she was immediately aware of smoke per her smell. She stated that she went through the closed fire doors on "A wing" and the area was filled with smoke and visibility was impaired. LPN #3 stated that LPN #1, LPN #2 and CNA #1 were all standing in the hallway of "A wing" looking at the floor where there was a blanket that had been on fire and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 90	F 689		

was not out. LPN #1 explained that she had put out the fire. The fire alarm was sounding and the sprinkler was not engaged. LPN #3 told the second floor staff to start an immediate investigation and to get statements from all involved. LPN #3 stated that they had no idea how to turn off the fire alarm. The Fire Department was on the scene and the fire alarm was sounding. LPN #3 called the Maintenance Director, to tell him of the fire and to get instructions as to how to turn off the fire alarm. The Maintenance Director explained how to turn off the fire alarm to LPN #3 and she re-set the alarm and turned it off. LPN #3 stated that the Fire Department did not re-set the fire alarm, they did not have to put out the fire because LPN #1 had put the fire out with a blanket. LPN #3 stated that she called the ADM and DON and they told her to relay to the staff up on second floor not to document the fire in the computer and not to document in the medical records of Res #1. LPN #3 went back upstairs and told LPN #1 and LPN #2 not to document the fire, as she had been told by the ADM. LPN #3 stated that she and LPN #1 went in to Res #1's room and he gave them a cigarette lighter from his pocket and LPN #3 got his permission to search his room and LPN #3 found a second cigarette lighter inside of a purple draw string bag which she took from Res #1 and placed in a box at the nursing station on the second floor. LPN #3 stated that Res #1 was unaware of what he had done. He told LPN #3 that he was cold and was trying to get warm. LPN #3 stated that she had not worked with Res #1 prior and she thought maybe he had had a dream or something. Res #1 talked about cars being in his room and friends talking to him and giving him a cigarette to light. LPN #3 stated that she had not been asked about the fire on 07/26/2021 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 91	F 689		

had not given a statement about the fire until 08/10/2021. LPN #3 has no knowledge of the fire having been reported and or investigated prior to 08/10/2021. LPN #3 stated that she has no knowledge of Res #1's care plan having been revised and she had no knowledge of assessments of Res #1 following the fire of 07/26/2021.

Interview on 08/14/2021 at 11:40 AM, with CNA #2, revealed that she was assigned to work the second floor on 07/26/2021. CNA #2 did not witness the fire, she was on her 15 minute break down stairs on the patio when she heard the fire alarm. CNA #2 returned to the unit to find the alarm sounding and the fire doors closed. The fire was out and she was told by the LPN's that it was bed linens that Res #1 set on fire. CNA #2 stated that she did not know the details and she had not been involved in any investigations. CNA #2 did not see Res #1 following the fire on 07/26/2021. CNA #2 stated that she did help close doors on the unit prior to the fire department arriving on the unit.

Interview on 08/14/2021 at 1:30 PM, with CNA #1, revealed that she was the second floor CNA on 07/26/2021 and she was the one that discovered the fire burning in the hallway outside of Res. #1's room. CNA #1 stated that she ran down the hall and yelled "FIRE" and that the linen cart was located close by the fire and she grabbed a "diaper" and tried to beat the fire out. LPN #1 and LPN #2 ran down the hall toward her, and LPN #1 expressed to CNA #1 to "stop fanning the fire" and let her put it out. LPN #1 grabbed a blanket off the linen cart and placed it over the burning bed sheets, putting the fire out. The fire alarm was sounding and the fire department did come

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 92	F 689		

to the facility. CNA #1 stated that the fire department did not talk to her and she had never been asked by any one to give a statement of the events. CNA had no knowledge of an investigation following the fire. CNA #1 stated that it all happened so fast and there was not time to grab a fire extinguisher. CNA #1 did not talk to Res #1. Res #1 was standing at his room door watching when they were putting out the fire. CNA #1 did not recall Res #7 witnessing the fire. CNA #1 stated that she did not document the fire and she was not asked to document any information.

The record review of Res #1's Admission Record revealed that he had been admitted to the facility on June 29, 2021, with admission diagnoses that included but were not limited to: Secondary Malignant Neoplasm of other specified sites; Malignant Neoplasm of Pancreas; Secondary Malignant Neoplasm of Liver and Intrahepatic Bile Duct; Secondary Malignant Neoplasm of Skin; Secondary and Unspecified Malignant Neoplasm of Intra-Abdominal Lymph Nodes; Pain Unspecified; Abnormal weight Loss; Personal History of Urinary (Tract) Infections; among other diagnoses.

The record review of Resident #1's Medical Record did not reveal that Resident #1 had been assessed for smoking and there were no psychosocial evaluations/assessments of his mental and behavioral health after the fire was set by Res #1 on 07/26/2021.

Record review of the Progress Notes for Res #1 since his admission of 06/29/2021 contained no information of his mental or behavioral assessments and/or monitoring of behaviors. There was no documentation in Res #1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 93	F 689		

Progress Notes documenting the fire of 07/26/2021.

The record review revealed that Res #1 had no Comprehensive Care Plan developed and he had no behavioral care plan developed. Res #1's medical record did not reflect the requirements outlined in the facility policies and procedures. The facility did not follow their policies and procedures for preventing accidents/hazards and for supervision of Res #1.

Record review of Res #1's "New Admit" History and Physical dated 7/1/2021 and written by the facility's Doctor of Nurse Practitioner (DNP) read: Past Medical History: Bladder cancer with mets to liver, pancreas, colon, HTN (Hypertension) Past Surgical History: Cystostopy Social History: Light Smoker; ETOH 6 cans a week; H/o (History of) marijuana use; Family History: Mother: Kidney cancer. Medication List: Morphine 60 mg 1 tablet extended release by mouth every twelve hours; Morphine 15 mg 1 tablet by mouth every four hours as needed. Plan: Medical records reviewed and signed. Admission orders reviewed and signed. Continue to monitor for any changes in condition as resident is high risk for complications related to multi comorbidities.

Record review of the hospital physician's History and Physical Note dated 05/27/2021 revealed: Social History: Tobacco Use Smoking Status: Light Tobacco Smoker Packs/day: 0.25 Alcohol use: Yes Alcohol/week: 6.0 standard drinks Types: 6 cans of beer per week Comment: Couple of times a week Drug Use: Yes Types: Marijuana Comment: couple weeks ago.

Record review of the facility admission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 94	F 689		

"INVENTORY LIST" dated 06/29/2021, for Res #1, was signed by the DON and did not document that Res #1 had a cigarette lighter upon his admission on 06/29/2021. The admission facility "INVENTORY LIST" for Res #1 documented that he had one (1) clear bag from the hospital and one (1) pair of socks documented on 06/29/2021. On 7/1/2021 "Acquired After Admission" was a black large shirt documented. There was no documentation on the "Inventory List" of the contents inside of Res #1's "clear hospital bag."

The record review of the Progress Notes in the medical record of resident #1 (Res #1) contained no documentation concerning the psychosocial well-being of Res #1 having been thoroughly assessed and care planned. There was no comprehensive person-centered plan of care in the medical record of Res #1, and no discharge plan for resident #1 documented in Res #1's medical record. The facility had not thoroughly evaluated the mental heath and psychosocial well-being of Res #1 and had not documented his plan for adjustment to the facility.

Record review of the admission "History and Physical" for Res #1, completed on July 1, 2021 by the facility's Doctor of Nurse Practitioner (DNP) documented: "Social History: Light Smoker Etoh (alcohol) 6 cans a week H/O (history of) marijuana use."

The record review of the "Inventory List" for Res #,1 dated 6/29/2021 and signed by the DON listed a clear (plastic) hospital bag. The Inventory List did not list the contents of the hospital bag. The contents of Res #1's socks, clothing and/or pockets were not documented in the medical records nor on the "Inventory List" for Res #1,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 95	F 689		

upon his admission to the facility on 06/29/2021.

Record review on 08/10/2021 of Res #1's medical records revealed there were no mental health assessments conducted for Res #1 following the fire of 07/26/2021. The record review revealed that the psychiatric nurse practitioner had not re-assessed Res #1 and there were no care plans to address Res #1's fire starting on 07/26/2021, and no care plans were observed in the medical records for behavioral health and mental health services discussed with Res #1. The Social Worker conducted a Brief Interview of Mental Status (BIMS) on 07/26/2021 and lowered his BIMS score one (1) point, from BIMS of 13, to BIMS of 12 which indicated "mild cognitive impairment." No mood changes were noted with the BIMS score. The record review revealed no progress notes documented by either of the two (2) Social Workers (SS's) for the fire of 07/26/2021 and the record review revealed no revision in the care plan of Res #1. There was no documentation in the medical records of Res #1 that documented the reason why the Social Worker Director (SSD) had completed the BIMS for Res #1 on 07/26/2021.

REMOVAL PLAN

The facility submitted a Removal Plan for the IJ. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ:

Brief Summary of Events

On 7//26/21 at approximately 1:30 am Licensed Practical Nurse LPN#1 reported witnessing a small fire and heard fire alarm sounding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 96	F 689		

simultaneously. Fire was located in middle of second floor A wing hall outside of Resident #1's room (210). Fire was located in center hall not encountering outside walls. LPN (Licensed Practical Nurse) #1 immediately extinguished fire by smothering with a blanket. LPN #! inspected area surrounding previous fire for any further active fires with none found. LP #2 contacted local fire department. LPN #1 and LPN #3 were going room to room with in location of the incident and reported Resident #1 was up sitting on edge of the bed upon entering the room. LPN #1 questioned Resident #1 on awareness of fire starting. Resident #1 reported he lit the fire because he was cold but when he started to get hot, he threw it out the room. Resident #1 was immediately assessed by LPN #1 for any injury with no injuries found. Resident#1 reported he was in possession of a lighter. Lighter was removed by LPN #1. After room search completed, a second lighter was removed by LPN #3. Resident #1 denied any pain. Resident #1 refused to answer on where he obtained the lighter from. Resident #1 reported he had lighter to keep him warm. No other Residents were in surrounding incident. Resident #1 had no roommate.

Corrective Actions

1- On 07/26/21 at approximately 1:30 A.M. LPN #2 called 91 1 while facility alarm was sounding. Sprinkler systems were not activated as fire induced levels did not reach needed levels to activate.

2 -On 7/26/21 at approximately 1:33 A.M. Resident #1 was assessed by LPN #1 and found to have no injuries. The facility has no outside

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 97	F 689		

legal representative for Resident #1. Resident #1 is his own Responsible Party.

3- On 7/26/21 at 1:39 A.M. Yazoo City File Department arrived on scene.

4.- On 7/26/21 at 1:43 A-M. LPN#2 contacted Administrator and Director of Nursing via text message.

5.- On 7/26/21 at 1:50 A. M. Administrator contacted facility.

6.- On 7/26/21 at I A.M. Yazoo City Fire Department cleared the scene and departed the facility.

7.- On 7/26/21 beginning at approximately 8:30 A.M. Director of Nursing, RN Supervisor #1, RN Supervisor #2, Assistant Director of Nursing (ADON), Medical Records, and Activity Director began resident room checks of the entire facility to ensure all lighters were removed. Room checks were completed and no lighters were found.

8.- On 7/26/21 beginning at approximately 10:30 A.M. Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, Licensed Nurses, housekeeping staff, business office staff, therapy staff, dietary staff, and administrative staff on Abuse and Neglect Prohibition Policy and Flammable materials and storage.

9.- On 7/28/21 at 12:30 P.M., the Medical Director, Administrator, Director Assistant Director of Nursing, Social Services, Nurse Practitioner, Activity Director Business Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 98	F 689		

Manager, Wound Care Nurse and Medical Records held Quality Assurance Performance Improvement Committee meeting where the file was discussed and Resident Safety.

10.- On 8/10/21 at approximately 12:30 P.M. Psychiatric Nurse Practitioner #1 assessed Resident #1 for psychosocial, emotional, and mental distress along with a review of all of Resident #1 current medications. Psychiatric Nurse Practitioner #1 recommended a medication addition to assist with anxiousness- Resident #1 declined medication

11.- On 8/10/21 at 4:02 P.M. State Agency (SA) notified facility Administrator, Director Nursing and Assistant Director of Nursing of Immediate Jeopardy (IJ) with substandard quality of care. State Agency Surveyor provided the facility with the Immediate Jeopardy (IJ) templates.

12.- On 8/10/21 at approximately 5:15 P.M. Director of Nursing, RN Supervisor #1, RN Supervisor #2, RN Supervisor #3, Assistant Director of Nursing (ADON), Medical Records, Business Office Manager, Assistant Business Office Manager, Admission Coordinator, Maintenance Director, and Activity Director began resident room cheeks to ensure that all lighters were removed. Room checks were completed, and no lighters were found. Room checks completed at approximately 6:00 P.M. on 8/10/21 of all rooms in the building.

13.- On 8/10/21 at 7:09 P.M. facility Administrator initiated automated phone reporting system alert to resident families and staff of combustible safety storage, including facility storage of lighters, asking families not to purchase

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 99	F 689		

flammable materials including new policy implementation of combustible safety to use in conjunction with the current fire prevention policy. This combustible safety policy was created by the Quality Assurance Performance Improvement committee and approved by the facility medical director. The system automatically sends alerts and contacts families and staff listed in resident's records and payroll system.

14.- On 8/10/21 beginning at 8:15 P.M. Staff Development Coordinator initiated education on Combustible Safety storage and fire prevention with staff and residents to include Certified Nursing Assistants, Licensed nurses, housekeeping staff, Business Office staff, Therapy staff, Dietary staff, and administrative staff on new Combustible Safety Policy. No staff will be allowed to work without completing.

15.- On 8/10/21 at 9:00 P.M. Mississippi State Department of Health notified of event and pending Life Safety notification.

16.- On 8/1 1/21 at 10:30 A.M Mississippi State Department of Life Safety notified of fire with unusual incident report submitted.

17.- On 8/11/21 at 10:45 A.M. Medical Director. Administrator, Director of Nursing, RN Superviseor and RN Supervisor #4, LPN #4 held Quality Assurance Performance Improvement Meeting to include notification of Immediate Jeopardy to review steps initiated to prevent any further occurrence including new policy on Combustible Safety Storage. Policy includes no flammable materials in Resident's possession regardless of smoking status.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 100	F 689		

18.- On 8/11/21 at 9:30 A.M. Resident Council Meeting Held with Activity Director, Activity Assistant, Admission Coordinator, Resident Council President, and 13 total residents were present to discuss the new policy on Combustible Safety to include facility storage of flammable materials regardless of smoking status.

19.- On 8/11/21 at 5:30 P.M. Mississippi State Department of Health added 3 additional Immediate Jeopardy's (IJ).

20.- On 08/11/21 at 6:00 P.M. Resident had a Smoking evaluation completed by Director of Nursing (DON) and deemed currently as non-smoker. This is second smoking evaluation completed on Resident since admission which was on 6/29/21.

21.- On 8/11/2021 at 6:45 P.M. Social Services Director (SSD) developed a plan of care based on Resident #1 hallucinations occurring on 7/26/21. Adjustments to be made to the plan of care in event of further behaviors on an as needed basis.

22.- On 08/11/2021 at 7:15 P.M. Psychosocial interviews were completed by Administrator #2 and Area Director of Business Development (ADBD)on eight (8) Residents with BIMS (Brief Interview Mental Status) of 13 or higher in the seven (7) surrounding rooms to Resident to assess for psychosocial, emotional. or mental distress surrounding fire event with no emotional concerns noted.

23.- On 8/11/2021 at 7:19 P.M. a body audit was completed on Resident #1 by the MDS (Minimum Data Set) Coordinator to assess for any injuries

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 101	F 689		

with no negative findings.

24.- On 08/1 1/2021 at 7:30 P-M. the Administrator and Director of Nursing received education on proper Abuse and Neglect Reporting and investigation guidelines following State and Federal Regulations by Senior Administrator from a sister facility.

25.- On 08/11/2021 at 8:40 P.M. Medical Director. Administrator, Director of Nursing, Corporate Clinical Specialist (CCS) and Area Director of Business Development (ADBD) held an Ad-Hoc Quality Assurance Performance Improvement Meeting to include notification of additional Immediate Jeopardy (IJ) tags F610, F656 and F742 with no further recommendations.

26.- On 8/11/2021 at approximately 9:30 P.M. in-services were initiated to include Care Plans with a focus on behaviors and investigations of unusual occurrences. No staff members will be able to work until they are in-serviced.

27.- Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of 08/11/21, and the Immediate Jeopardy was removed 08/12/21.

On Saturday August 14, 2021 the State Agency (SA) validated the facility ' s Removal Plan for the Immediate Jeopardy (IJ). Validations of the facility's Removal Plan was conducted through staff interview, observations, policy and procedure review, and record reviews. The SA ' s validations on 08/14/2021 revealed that the facility took the following actions to remove the IJ:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 102	F 689		

1-The SA validated through interview with LPN#3 on 08/14/2021 at 10:54 AM that on 07/26/21 at approximately 1:30 AM the facility fire alarm was sounding and the facility sprinkler systems were not activated as fire induced levels did not reach needed levels to activate the sprinkler system. LPN#3 validated that she called the Maintenance Director on 07/26/2021 at approximately 2:00 AM to obtain instructions as to how to reset the fire alarm after the fire had been extinguished by the facility staff.

2 -The SA validated through interview on 08/14/2021 at 10:54 AM with LPN#3, that she and LPN#1 had verbally assessed resident #1 on 7/26/21 at approximately 1:33 AM Resident #1 was verbally assessed by LPN #1 and found to have no injuries. The facility has no outside legal representative for Resident #1. Resident #1 is his own Responsible Party.

3- On 08/14/2021 at 9:00 AM the SA validated through record review of the City Fire Department ' s written report, that on 7/26/21 at 1:39 AM the City File Department arrived on the scene at the facility and the facility ' s fire alarm was sounding. Record review of the written City Fire Report validated that the fire was extinguished prior to their arrival at the facility.

4.- The SA validated through interview on 08/14/2021 at 10:54 AM with LPN#3 that on 7/26/21 at approximately 1:43 AM. LPN#3 had contacted the Administrator and Director of Nursing via text message that there had been a fire at the facility on 07/26/2021.

5.-The SA validated through interview on 08/14/2021 at 10:54 AM with LPN#3 that on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 103	F 689		

7/26/21 at 1:50 AM the Administrator contacted LPN#3 concerning the fire.

6.- The SA validated on 08/14/2021 through record review of the City Fire Department ' s Report that on 7/26/21 at 1:53 AM the City Fire Department cleared the scene and departed the facility. The SA also validated through interview on 08/14/2021 at 10:54 AM with LPN#3 that the City Fire Department came to the facility on 07/26/2021 at approximately 1:30 AM and left the facility at approximately 1:53 AM on 07/26/2021.

7.- The SA validated on 08/14/2021 through record review that on 7/26/21 beginning at approximately 8:30 AM Director of Nursing, RN Supervisor #1, RN Supervisor #2, Assistant Director of Nursing (ADON), Medical Records, and Activity Director began resident room checks of the entire facility to ensure all lighters were removed. Room checks were completed and no lighters were found.

8.-The SA validated on 08/14/2021 through record review of the In-Services sign-in/attendance sheets, that on 7/26/21 beginning at approximately 10:30 AM Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, Licensed Nurses, housekeeping staff, business office staff, therapy staff, dietary staff, and administrative staff on Abuse and Neglect Prohibition Policy and Flammable materials and storage.

9.- The SA validated through interview, and record review of the QA Meeting ' s sign-in/attendance sheet dated 07/28/2021, and with the facility Administrator (ADM) interview on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 104	F 689		

08/14/2021 at 10:00 AM that on 7/28/21 at 12:30 PM, the Medical Director, Administrator, Director Assistant Director of Nursing, Social Services, Nurse Practitioner, Activity Director Business Office Manager, Wound Care Nurse and Medical Records held Quality Assurance Performance Improvement Committee meeting where the file was discussed and Resident Safety.

10.-On 08/14/2021 the SA validated through record review that on 8/10/21 at approximately 12:30 PM the facility ' s Psychiatric Nurse Practitioner assessed Resident #1 for psychosocial, emotional, and mental distress along with a review of all of Resident #1 current medications. Psychiatric Nurse Practitioner recommended a medication addition to assist with anxiousness- Resident #1 declined medication.

11.-The SA validated on 08/14/2021 through record review that the IJ Templates were provided to the facility on 8/10/21 at 4:02 PM the SA validated through record review, that the notification of the IJ was provided to the facility Administrator, Director Nursing and Assistant Director of Nursing. The validation on 08/14/2021 by record review documented that the Immediate Jeopardy (IJ) with Substandard Quality of Care was provided in writing, to the facility, per the submission of the IJ Templates dated 08/10/2021 at 4:02 PM.

12.-On 08/14/2021 the SA validated through record review that on 8/10/21 at approximately 5:15 PM Director of Nursing, RN Supervisor #1, RN Supervisor #2, RN Supervisor #3, Assistant Director of Nursing (ADON), Medical Records, Business Office Manager, Assistant Business

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 105	F 689		

Office Manager, Admission Coordinator, Maintenance Director, and Activity Director began resident room cheeks to ensure that all lighters were removed. Room checks were completed, and no lighters were found. Room checks completed at approximately 6:00 PM on 8/10/21 of all rooms in the building.

13.-The SA validated on 08/14/2021 at 10:00 A.M. through interview with the facility ADM that on 8/10/21 at 7:09 PM the facility Administrator initiated automated phone reporting system alert to resident families and staff of combustible safety storage, including facility storage of lighters, asking families not to purchase flammable materials including new policy implementation of combustible safety to use in conjunction with the current fire prevention policy. This combustible safety policy was created by the Quality Assurance Performance Improvement committee and approved by the facility medical director. The system automatically sends alerts and contacts families and staff listed in resident's records and payroll system.

14.- On 08/14/2021 the SA validated through a record review, the In-Service sign-in/attendance sheets dated 8/10/21, that beginning at 8:15 PM the Staff Development Coordinator initiated education on Combustible Safety storage and fire prevention with staff and residents to include Certified Nursing Assistants, Licensed nurses, housekeeping staff, Business Office staff, Therapy staff, Dietary staff, and administrative staff on new Combustible Safety Policy. No staff will be allowed to work without completing.

15.-On 08/14/2021 a record review validated that on 8/10/21 at 9:00 PM the facility notified the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 106	F 689		

Mississippi State Department of Health of the 07/26/2021 fire event and of the pending Life Safety written notification.

16.- The SA validated through record review that on 08/14/2021 that on 8/1 1/21 at 10:30 AM Mississippi State Department of Life Safety notified of fire with unusual incident report submitted.

17.- The SA validated on 08/14/2021 through record review of the QA sign-in/attendance sheet and policy review that on 8/11/21 at 10:45 A.M. Medical Director. Administrator, Director of Nursing, RN Supervisor and LPN #4 held Quality Assurance Performance Improvement Meeting to include notification of Immediate Jeopardy to review steps initiated to prevent any further occurrence including new policy on Combustible Safety Storage. Policy includes no flammable materials in Resident's possession regardless of smoking status.

18.- The SA validated through record review on 08/14/2021 that on 8/11/21 at 9:30 A.M. the Resident Council Meeting was held with the Activity Director, Activity Assistant, Admission Coordinator, Resident Council President, and 13 total residents were present to discuss the new policy on Combustible Safety to include facility storage of flammable materials regardless of smoking status.

19.-The SA validated, through record review of the IJ Templates, on 08/14/2021, that on 8/11/21 at 5:30 PM the Mississippi State Department of Health added 3 additional Immediate Jeopardy's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 107	F 689		

(IJ). The additional IJ ' s were provided to the facility per the written IJ Templates for F610; F656; and F742.

20.- The SA Validated through record review on 08/14/2021, that on 08/11/21 at 6:00 PM Resident #1 had a Smoking evaluation completed by the Director of Nursing (DON) and was deemed as a non-smoker. This was the second smoking evaluation completed on Resident #1 since admission which was on 6/29/21.

21.-On 08/14/2021 at 11:50 P.M. the SA validated through an interview with the Social Services Director (SSD) and through record review of the care plan for Res #1, that on 8/11/2021 at 6:45 PM the Social Services Director (SSD) developed a Plan of Care based on Resident #1 ' s hallucinations that occurred on 7/26/21.

22.-The SA validated through record review on 08/14/2021 that on 08/11/2021 at 7:15 PM Psychosocial interviews were completed by Administrator #2 and Area Director of Business Development (ADBD)on eight (8) Residents with BIMS (Brief Interview Mental Status) of 13 or higher in the seven (7) surrounding rooms to Resident to assess for psychosocial, emotional. or mental distress surrounding fire event with no emotional concerns noted.

23.- The SA validated through record review on 08/14/2021 that on 8/11/2021 at 7:19 PM a body audit was completed on Resident #1 by the MDS (Minimum Data Set) Coordinator to assess for any injuries with no negative findings.

24.- The SA validated through record review and through interview on 08/14/2021 at 10:00 A.M.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 108	F 689		

with the facility ADM that on 08/1 1/2021 at 7:30 P-M. the Administrator and Director of Nursing received education on proper Abuse and Neglect Reporting and investigation guidelines following State and Federal Regulations by Senior Administrator from a sister facility.

25.- The SA validated on 08/14/2021 through record review of the QA sign-in/attendance sheets that on 08/11/2021 at 8:40 P.M. Medical Director. Administrator, Director of Nursing, Corporate Clinical Specialist (CCS) and Area Director of Business Development (ADBD) held an Ad-Hoc Quality Assurance Performance Improvement Meeting to include notification of additional Immediate Jeopardy (IJ) tags F610, F656 and F742 with no further recommendations.

26.- On 08/14/2021 from 10:54 A.M.-12:05 P.M. the SA interviewed seven (7) CNA ' s; two (2) RN ' s; Two (2) dietary workers; two(2) office staff; two (2) house keeping staff; four (4) LPN ' s; two (2) Social Workers; the facility ADM and the DON, to validate that all staff working on 8/11/2021 at approximately 9:30 P.M. were in-serviced and validated that in-services were initiated to include Care Plans with a focus on behaviors and investigations of unusual occurrences. The SA validated through interview and record review on 08/14/2021 with the ADM and DON, that no staff members will be able to work until they are in-serviced.

27.-The SA validated on 08/14/2021 from 10:00 A.M. through 12:25 PM via observations, record reviews, staff interviews, and policy and procedure reviews that the facility submitted a Removal Plan for the IJ. The SA validated through record reviews, staff interviews,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 109 observations, and policy and procedure reviews, that the facility had completed all the tasks outlined in the Removal Plan on 08/11/2021 and the IJ ' s were removed on 08/12/2021. On 08/14/2021 the State Agency (SA) validated, through interviews, record reviews, observations and policy and procedure reviews, that all corrective actions to remove the IJ, were completed on 08/11/2021 and the IJ was removed on 08/12/2021.	F 689		
F 742 SS=J	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, resident interviews, and policy and procedure reviews, the facility failed to thoroughly access and evaluate the treatment needs for Resident #1's mental and behavioral health, and failed to address Resident #1's psychosocial well-being, following a fire on 07/26/2021 that Resident #1 started in the facility. Resident #1 was one (1) of seven (7) residents reviewed for psychosocial well-being and mental and behavioral health.	F 742	1. On 07/26/21 at approximately 1:30 A.M. LPN #2 called 911 while facility alarm was sounding. Sprinkler systems were not activated as fire induced levels did not reach needed levels to activate. On 7/26/21 at approximately 1:33 A.M. Resident #1 was assessed by LPN #1 and found to have no injuries. The facility has no outside legal representative for Resident #1. Resident #1 is his own responsible party. On 7/26/21 at 1:39 A.M.	9/13/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 742	Continued From page 110 The facility's failed to adequately assess and develop a plan of care to reflect Resident #1's psychosocial well-being and failed to supervise Resident #1 during his admission adjustment to the facility. The facility's failure to prevent the potential for accidents and hazards resulted in Resident #1 setting his bed linens on fire and throwing them out into the hallway causing a fire that set off the fire alarms and caused the Fire Department to be dispatched to the facility in the early morning hours of 1:30 AM on 07/26/2021. This placed this resident and other residents at risk, in a situation that was likely to cause serious harm, injury, impairment or death. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 07/26/2021 when the facility's failure to provide supervision of Resident #1 as he obtained a cigarette lighter in his room and lit his bed linen on fire and threw the burning bed linens out into the hallway of the facility. On 08/11/2021 at 5:30 PM, the State Agency (SA) notified the facility Administrator of the IJ and SQC and the facility was presented with the IJ template. The facility submitted a credible Removal Plan on 08/12/2021 at 5:29 PM in which the facility alleged all corrective actions to remove the IJ were completed on 08/11/2021 and the IJ removed as of 08/12/2021. The SA validated the Removal Plan on 08/14/2021 and determined the IJ was removed prior to exit. Therefore, the scope and severity for 42 CFR 483.40(b)(1) Treatment and Services for Mental/Psychosocial Concerns (F742) was lowered from a "J" level scope and severity to a	F 742	Yazoo City Fire Department arrived on scene. On 7/26/21 at 1:43 A.M. LPN#2 contacted Administrator and Director of Nursing via text message. On 7/26/21 at 1:50 A. M. Administrator contacted facility. On 7/26/21 at 1:53 A.M. Yazoo City Fire Department cleared the scene and departed the facility. On 7/26/21 beginning at approximately 8:30 A.M. Director of Nursing, RN Supervisor #1, RN Supervisor #2, Assistant Director of Nursing (ADON), Medical Records, and Activity Director began resident room checks of the entire facility to ensure all lighters were removed. Room checks were completed, and no lighters were found. On 7/26/21 beginning at approximately 10:30 A.M. Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, Licensed Nurses, housekeeping staff, business office staff, therapy staff, dietary staff, and administrative staff on Abuse and Neglect Prohibition Policy and Flammable materials and storage. On 7/28/21 at 12:30 P.M., the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Social Services, Nurse Practitioner, Activity Director Business Office Manager, Wound Care Nurse and Medical Records held Quality Assurance Performance Improvement Committee meeting where the fire was discussed and Resident Safety. 2. From 8/11/21-8/13/21, an audit was conducted by Social Services on current	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 742	Continued From page 111 "D" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Record review of the facility policy "Behavioral Health Services" dated 7/22/2018 revealed, "Each resident must receive, and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Providing behavioral health care and services is an integral part of the person-centered environment. This involves an interdisciplinary approach to care, with qualified staff who demonstrate the competencies and skills necessary to provide appropriate services to the resident. Individualized approaches to care (including direct care and activities) are provided as part of a supportive physical, mental, and psychosocial environment, and are directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities..." Observation and interviews on 08/10/2021 at 6:15 AM of Resident #1 ' s room revealed that the floor in front of his room had an area of moderate size to be discolored with brown marks that would not rub off when surveyor rubbed the brown marks with her shoes. Registered Nurse (RN) #4 stated	F 742	residents admitted within the last ninety days in the facility to determine if these residents have been evaluated by psychiatric nurse practitioner to identify and address any psychosocial needs. Of the eleven (11) current resident who admitted in the last ninety days, all eleven (11) had been since by the psychiatric nurse practitioner. 3. Beginning on 8/12/21, Staff Development Coordinator initiated education with nursing, administrative, housekeeping, dietary, and contract staff on how to maintain psychosocial needs in residents. Beginning on 9/13/21, Staff Development Coordinator expanded on previous in service to include behavioral health services. On 8/11/21 going forward all new admissions will receive a psychosocial evaluation by Psychiatric nurse practitioner. All identified concerns will be addressed immediately. 4. Beginning 8/16/21 an audit will be conducted weekly for four (4) weeks and then monthly for three (3) months by the Director of Nursing to review completion of Psychiatric recommendations to ensure all residents psychosocial needs are accurately addressed for three (3) new admission. A report beginning 8/18/21 will be submitted to the Quality Assurance Performance Improvement committee monthly for four (4) months by the Social Services Director for review and further recommendations. The Director of Nursing is responsible for monitoring 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 _____	C 08/14/2021

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 742	Continued From page 112	F 742		

that she was not sure of what the brown discoloration was on the floor in front of Resident #1 ' s room. At that time a staff member identifying herself as Physical Therapy (PT) staff interrupted and said, "those brown marks are from Res #1 throwing his burning bed linens out in to the hall." "Those brown marks were not there prior to the fire." PT denied witnessing the fire. PT stated that the other staff had informed her about the fire and had shown her the brown marks to be where Res #1's burning bed linens were thrown.

Interview on 8/10/2021 at 6:54 A.M. with the Director of Nursing (DON) revealed that she had no knowledge of a fire at the facility in July 2021.

Interview on 08/10/2021 at 7:35 AM, with Certified Nursing Assistant (CNA#4) revealed CNA #4 had no knowledge of Res #1 having been placed on close observation or on regular rounds checks following the fire. CNA #4 stated that she had not been interviewed or questioned concerning Res #1's mental or physical health after the fire he set on 07/26/2021.

Interview and observation on 08/10/2021 at 7:38 A.M. with Resident #1 (Res #1) Res #1 stated that he was "having one of those bad days." He stated, "I really don't know what happened." Res #1 stated that he really believed that he was on too much medicine and that being over medicated caused him to set the fire. Res #1 stated that he really did not know what he set on fire or where he got it from "but I threw it out into the hallway." Res #1 stated that the fire department did come to the unit for the fire. Res #1 stated that the fire alarm was sounded when he threw the fire out in to the hallway. Res #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 742	Continued From page 113	F 742		

stated that he knew now that he was not supposed to have a lighter in his possession. Res #1 stated that the fire had burned the floor tiles in front of his bedroom. Res #1 denied any injury from the fire. "I was ok, I did not get hurt." During the interview with Res #1 on 08/10/2021, he had rapid disconnected speech. At times, when he was talking, he appeared to lose his concentration. The rhythm of his speech was pressured, and his command of his native English language was poor. At times, during the interview, Res #1 was difficult to understand. He rambled and mumbled in a soft "rapid" low voice. Resident #1 had a flat affect with little animation of facial expressions during the interview.

The record review of Res #1's "Face Sheet" revealed that he had been admitted to the facility on June 29, 2021, with diagnoses that included but were not limited to Secondary Malignant Neoplasm of other specified sites, Malignant Neoplasm of Pancreas, Secondary Malignant Neoplasm of Liver and Intrahepatic Bile Duct, Secondary Malignant Neoplasm of Skin, Secondary and Unspecified Malignant Neoplasm of Intra-Abdominal Lymph Nodes. Resident #1 (Res #1) had been living in the facility for 28 days when he set the fire on 07/26/2021.

Record review revealed that Resident #1 had been assessed for smoking but there were no psychosocial evaluations/assessments of his mental and behavioral health after the fire was set by Res #1 on 07/26/2021. The record review revealed that there was no mention of a fire in the interdisciplinary progress notes.

Interviews on 08/10/2021 at 9:06 A.M. with the two (2) facility Social Services (SS) revealed that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 742	Continued From page 114	F 742		

Director of SS (DSS) revealed the SS's have no knowledge of any assessments/evaluations that were done for Res #1 immediately following the fire on 07/26/2021. SS stated that they had very little information for a "Social History Report" for Res #1 because he was his own Responsible Party (RP). The SS's stated that the facility's Nurse Practitioner was supposed to have done an assessment on Res #1 following the fire, but they are not aware if it was completed as of 08/10/2021. The SS's stated that they "will look for paperwork."

Interview on 08/10/2021 at 2:22 PM, with LPN#5, stated that she called the social worker, and asked her to come up and interview Res #1. She stated that he was not acting like he normally acted. LPN#5 thought he was pacing and walking about his room and appeared anxious. LPN#5 thought that Res #1 needed to be assessed. LPN#5 stated that Res #1 was on a lot of medication. LPN#5 had not documented anything in the medical records of Res #1. LPN#5 did not have any conversation with the facility ADM or DON concerning Res #1. LPN#5 had no knowledge of Res #1 having been placed on rounds checks through the night and day and had no knowledge of Res #1 having been placed on close observation after the fire on 07/26/2021.

Record review of Res #1's medical records revealed there were no mental health assessments conducted for Res #1 following the fire of 07/26/2021. The record review revealed that the psychiatric nurse practitioner had not re-assessed Res #1. The Social Worker conducted a Brief Interview for Mental Status (BIMS) on 07/26/2021 and lowered his BIMS score one (1) point, from BIMS of 13, to BIMS of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 742	Continued From page 115	F 742		

12 which indicated "mild cognitive impairment." No mood changes noted with the BIMS score. The record review revealed no progress notes documented by either of the two (2) Social Workers (SS's) for the fire of 07/26/2021.There was no documentation in the medical records of Res #1 that documented the reason why the Social Worker Director (SSD) had completed the BIMS for Res #1 on 07/26/2021.

Interviews on 08/10/2021 at 3:45 PM, with the LPN #7 and RN #2 revealed that the 24-hour report that was kept at the nursing station on second floor contained no reports of the fire set by Res #1 on 07/26/2021. No assessments or change in conditions documented in the 24-hour report for Res #1 on 07/26/2021. Both nurses stated that all changes in conditions, changes in mental status, changes in medications, and incidents/accidents were to be documented in the 24-hour report and maintained at the nursing station. Both nurses confirmed that the fire set by Res #1 should have been an event that was documented in the 24-hour report at the nursing station. Both nurses confirmed that there was no documentation on 07/25/2021; 07/26/2021; and 07/27/2021 contained in the 24-hour report concerning Res #1 and the fire he set on the second floor.

Record review of the 24-hour reports were obtained and there was no fire documented on the 24-hour report for 7/25/2021-7/27/2021. There was no report of Res #1 documented in the 24-hour report. There was no change in condition for Res #1 documented in the 24-hour report.

Interview on 08/10/2021 at 3:51 P.M. with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 742	Continued From page 116	F 742		

ADM and the DON confirmed that they had not completed behavioral health assessments. The facility did not place Res #1 on close observation after the fire on 07/26/2021.

Record review of the admission "History and Physical" for Res #1, completed on July 1, 2021, by the facility's Doctor of Nurse Practitioner (DNP) NP revealed, "Social History: Light Smoker EtOH (alcohol) 6 cans a week H/O (history of) marijuana use ..."

Interview on 08/11/2021 at 11:21 A.M. with the two (2) Social Workers (SSD) and (ASSD) revealed that they had not made referrals for services such as hospice, behavioral and mental health assessments, and services. SSD stated that neither of the Social Workers had documented their conversations and/or observations of Res #1. SSD stated that the progress notes for Res #1 have not been updated following the fire on 07/26/2021. They stated Res #1 was delusional on 07/26/2021 and was unable to give a "sound" reason for starting the fire. The SSD stated that there is no documentation available in Res #1's medical records to address his mental health and no care plan to address Res #1's medication adjustments.

Interviews on 08/11/2021 at 2:47 P.M. with the three (3) second shift Certified Nursing Assistances (CNA#6, CNA #8, CNA #9) that were assigned to the second floor, revealed All three CNA's confirmed that they have not been instructed to look for behaviors of Res #1 following the fire he set. The CNA's stated that Res #1 was private and was not involved in facility activities and that Res #1 did not exchange in conversation with them. CNA #9 stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 742	Continued From page 117	F 742		

she was an agency employee and had worked at the facility on second shift for a while and that she knew very little about Res #1. CNA #9 stated: "he acts weird." CNA #8 stated that Res #1 "does his own thing and doesn't often respond." CNA #8 stated that Res #1 "refuses a lot." CNA #6 stated that Res #1 was a private person and the CNA's had little interaction with him because he was a private person.

Interview on 08/12/2021 at 12:40 PM, with LPN#2 confirmed that they did not remove any residents from the building, and they did not assess any residents after the fire. LPN #2 stated that they did not place Res #1 on a suicide watch, nor did they place Res #1 on any safety rounds checks after he set the fire on 07/26/2021. LPN#2 stated that Res #1 told them that he "just woke up and could not believe he had set the fire." Res #1 did not verbalize why he set the fire. He told the nurses that he was sitting in a car with some friends and decided to light a cigarette when he saw the fire. LPN #2 stated that Res #1 was quiet and rather calm after the fire. Res #1 never did admit to setting the fire. LPN#2 asked Res #1 if he was hurt, and he said "no." LPN #2 stated that she was told by other staff on second floor that Res #1 was not acting like he usually acted and they had thought he was "not himself." But because she had not worked with Res #1 prior to 07/26/2021 she had nothing to compare his actions too. LPN #2 stated that she stayed over until the morning shift and verbally reported what had happened with the fire to the morning staff, and she called the social worker to come up and talk to Res #1 because she thought he may need to have a talk with some staff that knew him better.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 742	Continued From page 118	F 742		

Interview on 08/12/2021 at 4:18 PM, with the Psychiatric Nurse Practitioner (PNP), confirmed that the facility had not notified him to assess Res #1 following the fire on 07/26/2021. He reported that he had no knowledge of the fire until 08/10/2021 after the surveyor entered the building to conduct an investigation. He stated that he would have usually been contacted after an event like setting a fire but had not been contacted. PNP stated that he happened to be in the facility on 08/10/2021, when a staff member approached him and asked him to talk to Res #1 because he had set a fire on 07/26/2021. PNP stated that he had not seen Res #1 since his admission assessment. PNP stated that Res #1 did not want to take anti-depressant medications and did not admit to having depression or anxiety. PNP stated that he did feel that Res #1 was depressed and somewhat anxious but that Res #1 denied these symptoms. PNP stated that he wrote an order for anti-depressant medications just in case Res #1 changed his mind. PNP stated that he did a medication review of all of Res #1's medications on 08/10/2021 when he saw Res #1.

Interview on 08/12/2021 at 8:30 PM, with LPN#1, revealed that she had been the one that put the fire out on the unit. LPN #1 stated that she and LPN #3 had gone in to talk to Res #1 immediately after the fire was put out on 07/26/2021 and he appeared "scared" and anxious. LPN #1 stated that he was not acting like he "normally" had and that he volunteered to give them the cigarette lighter from his pocket. She stated there were not any close observations or rounds checks following the fire on 07/26/2021. LPN #1 stated that Res #1 did not realize what he had done and when the Fire Department came to the unit he was pacing and walking in his room and was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 742	Continued From page 119	F 742		

anxious.

Interview on 08/14/2021 at 10:54 AM, with (LPN #3) revealed that Res #1 was unaware of what he had done. He told LPN #3 that he was cold and was trying to get warm. LPN #3 stated that she had not worked with Res #1 prior and she thought maybe he had had a dream or something. Res #1 talked about cars being in his room and friends talking to him and giving him a cigarette to light. LPN #3 stated that she had no knowledge of Res #1's assessments following the fire.

Record review of the progress notes for Res #1 since his admission of 06/29/2021, contained no information of his mental or behavioral assessments and/or monitoring of behaviors. There was no documentation in Res #1's progress notes documenting the fire of 07/26/2021. The record review revealed that Res #1 had voiced delusional thoughts following the fire that he set on 07/26/2021. The facility record review did not reveal documentation that the facility had appropriately addressed Res #1's delusions. The facility had not documented any attempts at obtaining behavioral health services for Res #1 immediately following the fire set by Res #1 on 07/26/2021.

REMOVAL PLAN

The facility submitted a Removal Plan for the IJ. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ:

Brief Summary of Events

On 7//26/21 at approximately 1:30 am Licensed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 742	Continued From page 120	F 742		

Practical Nurse LPN#1 reported witnessing a small fire and heard fire alarm sounding simultaneously. Fire was located in middle of second floor A wing hall outside of Resident #1's room (210). Fire was located in center hall not encountering outside walls. LPN (Licensed Practical Nurse) #1 immediately extinguished fire by smothering with a blanket. LPN #! inspected area surrounding previous fire for any further active fires with none found. LP #2 contacted local fire department. LPN #1 and LPN #3 were going room to room with in location of the incident and reported Resident #1 was up sitting on edge of the bed upon entering the room. LPN #1 questioned Resident #1 on awareness of fire starting. Resident #1 reported he lit the fire because he was cold but when he started to get hot, he threw it out the room. Resident #1 was immediately assessed by LPN #1 for any injury with no injuries found. Resident#1 reported he was in possession of a lighter. Lighter was removed by LPN #1. After room search completed, a second lighter was removed by LPN #3. Resident #1 denied any pain. Resident #1 refused to answer on where he obtained the lighter from. Resident #1 reported he had lighter to keep him warm. No other Residents were in surrounding incident. Resident #1 had no roommate.

Corrective Actions

1- On 07/26/21 at approximately 1:30 A.M. LPN #2 called 91 1 while facility alarm was sounding. Sprinkler systems were not activated as fire induced levels did not reach needed levels to activate.

2 -On 7/26/21 at approximately 1:33 A.M.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 742	Continued From page 121	F 742		

Resident #1 was assessed by LPN #1 and found to have no injuries. The facility has no outside legal representative for Resident #1. Resident #1 is his own Responsible Party.

3- On 7/26/21 at 1:39 A.M. Yazoo City File Department arrived on scene.

4.- On 7/26/21 at 1:43 A-M. LPN#2 contacted Administrator and Director of Nursing via text message.

5.- On 7/26/21 at 1:50 A. M. Administrator contacted facility.

6.- On 7/26/21 at I A.M. Yazoo City Fire Department cleared the scene and departed the facility.

7.- On 7/26/21 beginning at approximately 8:30 A.M. Director of Nursing, RN Supervisor #1, RN Supervisor #2, Assistant Director of Nursing (ADON), Medical Records, and Activity Director began resident room checks of the entire facility to ensure all lighters were removed. Room checks were completed, and no lighters were found.

8.- On 7/26/21 beginning at approximately 10:30 A.M. Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, Licensed Nurses, housekeeping staff, business office staff, therapy staff, dietary staff, and administrative staff on Abuse and Neglect Prohibition Policy and Flammable materials and storage.

9.- On 7/28/21 at 12:30 P.M., the Medical Director, Administrator, Director Assistant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 742	Continued From page 122	F 742		

Director of Nursing, Social Services, Nurse Practitioner, Activity Director Business Office Manager, Wound Care Nurse and Medical Records held Quality Assurance Performance Improvement Committee meeting where the file was discussed and Resident Safety.

10.- On 8/10/21 at approximately 12:30 P.M. Psychiatric Nurse Practitioner #1 assessed Resident #1 fi)r psychosocial, emotional, and mental distress along with a review of all of Resident #1 current medications. Psychiatric Nurse Practitioner #1 recommended a medication addition to assist with anxiousness- Resident #1 declined medication

11.- On 8/10/21 at 4:02 P.M. State Agency (SA) notified facility Administrator, Director Nursing and Assistant Director of Nursing of Immediate Jeopardy (IJ) with substandard quality of care. State Agency Surveyor provided the facility with the Immediate Jeopardy (IJ) templates.

12.- On 8/10/21 at approximately 5:15 P.M. Director of Nursing, RN Supervisor #1, RN Supervisor #2, RN Supervisor #3, Assistant Director of Nursing (ADON), Medical Records, Business Office Manager, Assistant Business Office Manager, Admission Coordinator, Maintenance Director, and Activity Director began resident room cheeks to ensure that all lighters were removed. Room checks were completed, and no lighters were found. Room checks completed at approximately 6:00 P.M. on 8/10/21 of all rooms in the building.

13.- On 8/10/21 at 7:09 P.M. facility Administrator initiated automated phone reporting system alert to resident families and staff of combustible

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 742	Continued From page 123	F 742		

safety storage, including facility storage of lighters, asking families not to purchase flammable materials including new policy implementation of combustible safety to use in conjunction with the current fire prevention policy. This combustible safety policy was created by the Quality Assurance Performance Improvement committee and approved by the facility medical director. The system automatically sends alerts and contacts families and staff listed in resident's records and payroll system.

14.- On 8/10/21 beginning at 8:15 P.M. Staff Development Coordinator initiated education on Combustible Safety storage and fire prevention with staff and residents to include Certified Nursing Assistants, Licensed nurses, housekeeping staff, Business Office staff, Therapy staff, Dietary staff, and administrative staff on new Combustible Safety Policy. No staff will be allowed to work without completing.

15.- On 8/10/21 at 9:00 P.M. Mississippi State Department of Health notified of event and pending Life Safety notification.

16.- On 8/1 1/21 at 10:30 A.M Mississippi State Department of Life Safety notified of fire with unusual incident report submitted.

17.- On 8/11/21 at 10:45 A.M. Medical Director. Administrator, Director of Nursing, RN Supervisor and RN Supervisor #4, LPN #4 held Quality Assurance Performance Improvement Meeting to include notification of Immediate Jeopardy to review steps initiated to prevent any further occurrence including new policy on Combustible Safety Storage. Policy includes no flammable materials in Resident's possession regardless of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 742	Continued From page 124	F 742		

smoking status.

18.- On 8/11/21 at 9:30 A.M. Resident Council Meeting Held with Activity Director, Activity Assistant, Admission Coordinator, Resident Council President, and 13 total residents were present to discuss the new policy on Combustible Safety to include facility storage of flammable materials regardless of smoking status.

19.- On 8/11/21 at 5:30 P.M. Mississippi State Department of Health added 3 additional Immediate Jeopardy's (IJ).

20.- On 08/11/21 at 6:00 P.M. Resident had a Smoking evaluation completed by Director of Nursing (DON) and deemed currently as non-smoker. This is second smoking evaluation completed on Resident since admission which was on 6/29/21.

21.- On 8/11/2021 at 6:45 P.M. Social Services Director (SSD) developed a plan of care based on Resident #1 hallucinations occuring on 7/26/21. Adjustments to be made to the plan of care in event of further behaviors on an as needed basis.

22.- On 08/11/2021 at 7:15 P.M. Psychosocial interviews were completed by Administrator #2 and Area Director of Business Development (ADBD)on eight (8) Residents with BIMS (Brief Interview Mental Status) of 13 or higher in the seven (7) surrounding rooms to Resident to assess for psychosocial, emotional. or mental distress surrounding fire event with no emotional concerns noted.

23.- On 8/11/2021 at 7:19 P.M. a body audit was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 742	Continued From page 125	F 742		

completed on Resident #1 by the MDS (Minimum Data Set) Coordinator to assess for any injuries with no negative findings.

24.- On 08/1 1/2021 at 7:30 P-M. the Administrator and Director of Nursing received education on proper Abuse and Neglect Reporting and investigation guidelines following State and Federal Regulations by Senior Administrator from a sister facility.

25.- On 08/11/2021 at 8:40 P.M. Medical Director. Administrator, Director of Nursing, Corporate Clinical Specialist (CCS) and Area Director of Business Development (ADBD) held an Ad-Hoc Quality Assurance Performance Improvement Meeting to include notification of additional Immediate Jeopardy (IJ) tags F610, F656 and F742 with no further recommendations.

26.- On 8/11/2021 at approximately 9:30 P.M. in-services were initiated to include Care Plans with a focus on behaviors and investigations of unusual occurrences. No staff members will be able to work until they are in-serviced.

27.- Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of 08/11/21, and the Immediate Jeopardy was removed 08/12/21.

On Saturday August 14, 2021 the State Agency (SA) validated the facility's Removal Plan for the Immediate Jeopardy (IJ). Validations of the facility's Removal Plan was conducted through staff interview, observations, policy and procedure review, and record reviews. The SA's validations on 08/14/2021 revealed that the facility took the following actions to remove the IJ:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 742	Continued From page 126	F 742		

1-The SA validated through interview with LPN#3 on 08/14/2021 at 10:54 AM that on 07/26/21 at approximately 1:30 AM the facility fire alarm was sounding and the facility sprinkler systems were not activated as fire induced levels did not reach needed levels to activate the sprinkler system. LPN#3 validated that she called the Maintenance Director on 07/26/2021 at approximately 2:00 AM to obtain instructions as to how to reset the fire alarm after the fire had been extinguished by the facility staff.

2 -The SA validated through interview on 08/14/2021 at 10:54 AM with LPN#3, that she and LPN#1 had verbally assessed resident #1 on 7/26/21 at approximately 1:33 AM Resident #1 was verbally assessed by LPN #1 and found to have no injuries. The facility has no outside legal representative for Resident #1. Resident #1 is his own Responsible Party.

3- On 08/14/2021 at 9:00 AM the SA validated through record review of the City Fire Department's written report, that on 7/26/21 at 1:39 AM the City File Department arrived on the scene at the facility and the facility ' s fire alarm was sounding. Record review of the written City Fire Report validated that the fire was extinguished prior to their arrival at the facility.

4.- The SA validated through interview on 08/14/2021 at 10:54 AM with LPN#3 that on 7/26/21 at approximately 1:43 AM. LPN#3 had contacted the Administrator and Director of Nursing via text message that there had been a fire at the facility on 07/26/2021.

5.-The SA validated through interview on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 742	Continued From page 127	F 742		

08/14/2021 at 10:54 AM with LPN#3 that on 7/26/21 at 1:50 AM the Administrator contacted LPN#3 concerning the fire.

6.- The SA validated on 08/14/2021 through record review of the City Fire Department's Report that on 7/26/21 at 1:53 AM the City Fire Department cleared the scene and departed the facility. The SA also validated through interview on 08/14/2021 at 10:54 AM with LPN#3 that the City Fire Department came to the facility on 07/26/2021 at approximately 1:30 AM and left the facility at approximately 1:53 AM on 07/26/2021.

7.- The SA validated on 08/14/2021 through record review that on 7/26/21 beginning at approximately 8:30 AM Director of Nursing, RN Supervisor #1, RN Supervisor #2, Assistant Director of Nursing (ADON), Medical Records, and Activity Director began resident room checks of the entire facility to ensure all lighters were removed. Room checks were completed and no lighters were found.

8.-The SA validated on 08/14/2021 through record review of the In-Services sign-in/attendance sheets, that on 7/26/21 beginning at approximately 10:30 AM Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, Licensed Nurses, housekeeping staff, business office staff, therapy staff, dietary staff, and administrative staff on Abuse and Neglect Prohibition Policy and Flammable materials and storage.

9.- The SA validated through interview, and record review of the QA Meeting ' s sign-in/attendance sheet dated 07/28/2021, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 742	Continued From page 128	F 742		

with the facility Administrator (ADM) interview on 08/14/2021 at 10:00 AM that on 7/28/21 at 12:30 PM, the Medical Director, Administrator, Director Assistant Director of Nursing, Social Services, Nurse Practitioner, Activity Director Business Office Manager, Wound Care Nurse and Medical Records held Quality Assurance Performance Improvement Committee meeting where the file was discussed and Resident Safety.

10.-On 08/14/2021 the SA validated through record review that on 8/10/21 at approximately 12:30 PM the facility's Psychiatric Nurse Practitioner assessed Resident #1 for psychosocial, emotional, and mental distress along with a review of all of Resident #1 current medications. Psychiatric Nurse Practitioner recommended a medication addition to assist with anxiousness- Resident #1 declined medication.

11.-The SA validated on 08/14/2021 through record review that the IJ Templates were provided to the facility on 8/10/21 at 4:02 PM the SA validated through record review, that the notification of the IJ was provided to the facility Administrator, Director Nursing and Assistant Director of Nursing. The validation on 08/14/2021 by record review documented that the Immediate Jeopardy (IJ) with Substandard Quality of Care was provided in writing, to the facility, per the submission of the IJ Templates dated 08/10/2021 at 4:02 PM.

12.-On 08/14/2021 the SA validated through record review that on 8/10/21 at approximately 5:15 PM Director of Nursing, RN Supervisor #1, RN Supervisor #2, RN Supervisor #3, Assistant Director of Nursing (ADON), Medical Records,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 742	Continued From page 129	F 742		

Business Office Manager, Assistant Business Office Manager, Admission Coordinator, Maintenance Director, and Activity Director began resident room cheeks to ensure that all lighters were removed. Room checks were completed, and no lighters were found. Room checks completed at approximately 6:00 PM on 8/10/21 of all rooms in the building.

13.-The SA validated on 08/14/2021 at 10:00 A.M. through interview with the facility ADM that on 8/10/21 at 7:09 PM the facility Administrator initiated automated phone reporting system alert to resident families and staff of combustible safety storage, including facility storage of lighters, asking families not to purchase flammable materials including new policy implementation of combustible safety to use in conjunction with the current fire prevention policy. This combustible safety policy was created by the Quality Assurance Performance Improvement committee and approved by the facility medical director. The system automatically sends alerts and contacts families and staff listed in resident's records and payroll system.

14.- On 08/14/2021 the SA validated through a record review, the In-Service sign-in/attendance sheets dated 8/10/21, that beginning at 8:15 PM the Staff Development Coordinator initiated education on Combustible Safety storage and fire prevention with staff and residents to include Certified Nursing Assistants, Licensed nurses, housekeeping staff, Business Office staff, Therapy staff, Dietary staff, and administrative staff on new Combustible Safety Policy. No staff will be allowed to work without completing.

15.-On 08/14/2021 a record review validated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 742	Continued From page 130	F 742		

on 8/10/21 at 9:00 PM the facility notified the Mississippi State Department of Health of the 07/26/2021 fire event and of the pending Life Safety written notification.

16.- The SA validated through record review that on 08/14/2021 that on 8/11/21 at 10:30 AM Mississippi State Department of Life Safety notified of fire with unusual incident report submitted.

17.- The SA validated on 08/14/2021 through record review of the QA sign-in/attendance sheet and policy review that on 8/11/21 at 10:45 A.M. Medical Director. Administrator, Director of Nursing, RN Supervisor and LPN#4 held Quality Assurance Performance Improvement Meeting to include notification of Immediate Jeopardy to review steps initiated to prevent any further occurrence including new policy on Combustible Safety Storage. Policy includes no flammable materials in Resident's possession regardless of smoking status.

18.- The SA validated through record review on 08/14/2021 that on 8/11/21 at 9:30 A.M. the Resident Council Meeting was held with the Activity Director, Activity Assistant, Admission Coordinator, Resident Council President, and 13 total residents were present to discuss the new policy on Combustible Safety to include facility storage of flammable materials regardless of smoking status.

19.-The SA validated, through record review of the IJ Templates, on 08/14/2021, that on 8/11/21 at 5:30 PM the Mississippi State Department of Health added 3 additional Immediate Jeopardy's (IJ). The additional IJ's were provided to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 742	Continued From page 131	F 742		

facility per the written IJ Templates for F610; F656; and F742.

20.- The SA Validated through record review on 08/14/2021, that on 08/11/21 at 6:00 PM Resident #1 had a Smoking evaluation completed by the Director of Nursing (DON) and was deemed as a non-smoker. This was the second smoking evaluation completed on Resident #1 since admission which was on 6/29/21.

21.-On 08/14/2021 at 11:50 P.M. the SA validated through an interview with the Social Services Director (SSD) and through record review of the care plan for Res #1, that on 8/11/2021 at 6:45 PM the Social Services Director (SSD) developed a Plan of Care based on Resident #1's hallucinations that occurred on 7/26/21.

22.-The SA validated through record review on 08/14/2021 that on 08/11/2021 at 7:15 PM Psychosocial interviews were completed by Administrator #2 and Area Director of Business Development (ADBD)on eight (8) Residents with BIMS (Brief Interview Mental Status) of 13 or higher in the seven (7) surrounding rooms to Resident to assess for psychosocial, emotional. or mental distress surrounding fire event with no emotional concerns noted.

23.- The SA validated through record review on 08/14/2021 that on 8/11/2021 at 7:19 PM a body audit was completed on Resident #1 by the MDS (Minimum Data Set) Coordinator to assess for any injuries with no negative findings.

24.- The SA validated through record review and through interview on 08/14/2021 at 10:00 A.M. with the facility ADM that on 08/11/2021 at 7:30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 742	Continued From page 132	F 742		

P-M. the Administrator and Director of Nursing received education on proper Abuse and Neglect Reporting and investigation guidelines following State and Federal Regulations by Senior Administrator from a sister facility.

25.- The SA validated on 08/14/2021 through record review of the QA sign-in/attendance sheets that on 08/11/2021 at 8:40 P.M. Medical Director. Administrator, Director of Nursing, Corporate Clinical Specialist (CCS) and Area Director of Business Development (ADBD) held an Ad-Hoc Quality Assurance Performance Improvement Meeting to include notification of additional Immediate Jeopardy (IJ) tags F610, F656 and F742 with no further recommendations.

26.- On 08/14/2021 from 10:54 A.M.-12:05 P.M. the SA interviewed seven (7) CNA's; two (2) RN's; Two (2) dietary workers; two(2) office staff; two (2) house keeping staff; four (4) LPN's; two (2) Social Workers; the facility ADM and the DON, to validate that all staff working on 8/11/2021 at approximately 9:30 P.M. were in-serviced and validated that in-services were initiated to include Care Plans with a focus on behaviors and investigations of unusual occurrences. The SA validated through interview and record review on 08/14/2021 with the ADM and DON, that no staff members will be able to work until they are in-serviced.

27.-The SA validated on 08/14/2021 from 10:00 A.M. through 12:25 PM via observations, record reviews, staff interviews, and policy and procedure reviews that the facility submitted a Removal Plan for the IJ. The SA validated through record reviews, staff interviews, observations, and policy and procedure reviews,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 08/14/2021

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 742	Continued From page 133 that the facility had completed all the tasks outlined in the Removal Plan on 08/11/2021 and the IJ 's were removed on 08/12/2021. On 08/14/2021 the State Agency (SA) validated, through interviews, record reviews, observations and policy and procedure reviews, that all corrective actions to remove the IJ, were completed on 08/11/2021 and the IJ was removed on 08/12/2021.	F 742		