Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	**925 CALHOUN AVENUE , YAZOO CITY, Mississippi, 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
M0000	Initial Comments The State Agency (SA) conducted a complaint investigation (CI #475956, CI #475957, CI #475959, CI #2565767, CI #2587483, CI #2589906, CI #2592662) at the facility from 9/15/25 through 9/16/25. During the survey, the SA determined that the facility was not in compliance with the requirements of the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The SA identified non-compliance and cited M 500 for CI #475959 for failure to protect a resident from misappropriation of funds, and M 640 for CI # 2592662 for failure to implement interventions to prevent accidents. There were no deficiencies cited for CI #475956, CI #475957, CI #2565767, CI #2587483, or CI #2589906. The census at the time of the survey was 124 with a bed capacity of 180 beds.	M0000		
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care,	M0500		

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

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M0500	Continued from page 1 is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat	M0500		

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M0500	Continued from page 2 to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);	M0500		

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M0500	Continued from page 3 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on resident and staff interviews, facility investigation review, record review and facility policy review, the facility failed ensure a residents right to be free from misappropriation for one (1) of five (5) residents reviewed for misappropriation of resident funds, Resident #2. A Certified Nursing Assistant (CNA) misappropriated money from the resident's trust fund account and Cash App account. Findings Include Review of the facility policy titled "Abuse Prohibition Policy" latest review date 6/2/25, revealed, "Intent... Each resident has the right to be free from abuse, mistreatment, neglect, corporal punishment, involuntary seclusion and financial abuse...The facility will prohibit neglect, mental or physical abuse, including involuntary seclusion and the misappropriation of resident property or finances of residents..." Record review of the facility investigation revealed that on 6/12/25 Resident #2 notified the Administrator (ADM) that Certified Nursing Assistant (CNA) #1 had stolen money from her via her trust fund card and Cash App. Resident #2 stated that starting in November 2024 she would send CNA #1 money through Cash App to buy her food and that she would pay CNA #1 additional money to do so. She stated that in April 2025 she received her trust fund card, and she gave it to CNA #1 to continue buying food for her. Resident #2 reported that she started noticing additional charges that she had not authorized. In an interview with CNA #1, she told the ADM that she did not have a Cash App account. Review of screenshots provided by Resident #2 showed transactions between herself and "Proper Name and Cash App identification (ID)," which was identified as belonging	M0500		

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M0500	Continued from page 4 to CNA #1. She also provided copies of her trust fund account transactions. CNA #1 was suspended pending investigation and was terminated on 6/17/25. An interview with the ADM on 9/15/25 at 11:00 AM revealed she received a complaint from Resident #2 on 6/12/25 stating that CNA #1 had stolen approximately $10,000 from her through Cash App and her trust fund card. The ADM stated that Resident #2 reported she had asked CNA #1 to purchase food for her and paid her additional money to do so. The ADM confirmed that Resident #2 gave her trust fund card to CNA #1 so that she could continue to purchase items, but she noticed unauthorized charges on the card. When confronted, CNA #1 denied the charges, and Resident #2 reported the matter. The ADM verified that CNA #1 was suspended pending investigation on 6/12/25 and terminated on 6/17/25 due to misappropriation. In an interview with Social Services (SS) and the Activity Director (AD) on 9/15/25 at 12:15 PM, they stated that it is the practice of the facility for SS or AD to shop for residents and staff are aware. They stated they do not take resident debit cards or receive money via Cash App, and that Resident #2 never asked them to shop for her. A record review of screenshots of Cash App transactions between Resident #2 and an account identified as belonging to CNA #1, which occurred between November 19, 2024, and June 2025, revealed a total of 106 transactions of varying amounts. The screenshots showed a total of $10,963.13 sent to CNA #1 that were identified on the Cash App subject as food, etc. A record review of Resident #2's trust fund account summary for 4/1/25 through 4/30/25 showed a total of 20 withdrawals, of varying amounts, totaling $964.77, that Resident #2 indicated were not authorized by her. A record review of Resident #2's trust fund account summary for 5/1/25 through 5/31/25 showed a total of 48 withdrawals, of varying amounts, totaling $2,460.56, that Resident #2 indicated were not authorized by her. An interview with Resident #2 on 9/15/25 at 12:21 PM revealed that sometime in November 2024 she started asking CNA #1 to shop for her. She stated that she would send her money via Cash App for the purchases, and that CNA #1 charged her additional fees for doing the shopping. She stated that in April 2025 she received her trust fund card and gave it to CNA #1 so she would have it to shop for her. Resident #2 stated that she started noticing additional charges on her	M0500		

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M0500	Continued from page 5 trust fund card. She reported seeing one of CNA #1's Snapchat stories of her dining at a Mexican restaurant that coincided with one of the unauthorized charges. Resident #2 stated she reached out to CNA #1, who denied the unauthorized charges, so she reported the matter to the ADM. Resident #2 explained that she had no one else to shop for her and asked CNA #1 for help, but realized CNA #1 was taking advantage of her when the additional charges appeared. She stated she was not aware that Social Services or Activities would shop for residents. Resident #2 verified that the Cash App name and ID on the screenshots from November 19, 2024, through June 2025 belonged to CNA #1. She also verified that the transactions she circled on the April 2025 and May 2025 trust fund account summaries were not authorized by her and she believed they were made by CNA #1. Record review of the Quarterly Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 7/3/25 revealed Resident #2 had a Brief Interview of Mental Status (BIMS) score of 15, indicating she is cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #2 on 5/20/22 with a diagnosis of Quadriplegia, C1-C4 incomplete.	M0500		
M0640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level III Based on observation, interview, facility policy review, and record review, the facility failed to ensure effective supervision and accident prevention interventions were in place to mitigate the risk of falls for one (1) of three (3) residents reviewed for accidents (Resident #1). This deficient practice resulted in the resident sustaining a fall with a laceration and hematoma to the left eyebrow, requiring emergency department treatment. Findings Include A review of the facility policy titled, "Fall	M0640		

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M0640	Continued from page 6 Prevention Program," review date 6/18/25 revealed: "All residents will be assessed for the risk for falls at the time of admission, on a quarterly basis, and upon significant change in condition thereafter. Based on the results of this assessment, specific interventions will be implemented to minimize falls, avoid repeat falls, and minimize falls resulting in significant injury… The resident's plan of care will be updated to reflect risk for falls and appropriate interventions… If a fall occurs… the plan of care will be updated to reflect interventions." A record review of "Progress Notes" and "Incident Descriptions" revealed Resident #1 experienced five (5) falls between 11/2024 and 08/2025. This review revealed that on 11/23/2024 at 8:15 AM, the resident was found on the dining hall floor in front of his Geri-chair. He stated he missed the chair and did not recall where he was going. No injuries were noted. Again on 5/26/2025 at 8:25 AM, the resident was found lying on the floor of his room on his left side and stated that he rolled off the couch. No injuries were noted. On 6/17/2025 at 8:45 AM, the resident was found on the floor beside his bed. He stated he rolled out of bed. No injuries were noted. On 7/7/2025 at 5:04 PM, the resident was found lying on the floor of his room on the left side of the bed. No injuries were noted. And finally, on 8/14/2025 at 9:00 AM, the resident was found lying between the wall and bed, with his feeding pump overturned and his head turned to the side. There was blood around the resident's face, and he sustained a laceration and hematoma to the left eyebrow. The resident was unable to describe what occurred. He was transferred to the emergency room for evaluation and treatment. A record review of the "After Visit Summary" dated 8/14/2025 revealed the Resident #1 sustained a two (2) centimeter laceration to the left eyebrow, which was repaired using glue and steri-strips. A Computed Tomography Scan (CT) of the head without contrast noted "no acute intracranial abnormality," but a "left forehead scalp contusion and/or small hematoma" was identified. On 9/16/2025 at 8:30 AM, during an interview with Licensed Practical Nurse #1 (LPN) she explained that Resident #1's bed had been positioned with the right side against the wall since she began working at the facility several months prior. She stated the room was set up that way, and the bed was placed against the wall due to the resident's fall history. She confirmed she was on duty on 8/14/2025 when the resident fell and explained that he had fallen between the wall and the bed, though she was unsure how it occurred.	M0640		

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M0640	Continued from page 7 On 9/16/2025 at 10:26 AM, during a telephone interview, Certified Nurse Aide #1(CNA) explained she was assigned to the resident on 8/14/2025. She reported the bed had been locked and positioned against the wall prior to the fall. She added that the resident sometimes pushed against the wall, and she believed that is how the bed shifted, and the resident fell. A record review of the “Care Plan Report” for Resident #1 revealed a focus of “risk for falls” related to Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting the left dominant side, Hypertension, and blindness. The report listed individual entries acknowledging the five falls, but no new interventions were documented following any of the incidents on 11/23/2024, 5/26/2025, 6/17/2025, 7/7/2025, or 8/14/2025. On 9/16/2025 at 12:30 PM, during an interview and record review with the Assistant Director of Nursing (ADON), she confirmed the facility had not initiated new interventions following the resident’s repeated falls but should have. Record review of the "Admission Record" revealed the facility originally admitted Resident #1 on 4/1/24 with a diagnosis of Hemiplegia and Hemiparesis following unspecified Cerebrovascular Disease affecting the left dominant side.	M0640		