

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255146		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/16/2025	
NAME OF PROVIDER OR SUPPLIER YAZOO CITY REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F0000	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 participation in Medicare and Medicaid Services. The SA identified non-compliance and cited F602 for CI #475959 for failure to protect a resident from misappropriation of funds, F657 and F689 for CI # 2592662 for failure to revise the care plan and 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.		F0000				
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: 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		F0602				

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0602 SS = D	Continued from page 1 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 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.	F0602					

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F0602 SS = D	Continued from page 2 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 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.			F0602			

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F0602 F0657 SS = G	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review and facility policy review, the facility failed to update a care plan after a residents falls for one (1) of three (3) resident care plans reviewed. Resident #1 Findings Include A review of the facility policy titled, "Fall Prevention Program," 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... The resident's plan of care will be updated to reflect risk for falls and appropriate interventions... If a fall occurs... the plan			F0602 F0657			

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F0657 SS = G	Continued from page 4 of care will be updated to reflect interventions." A record review of the "Care Plan Report" for Resident #1 revealed a focus of "The resident is at risk for falls related to Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting the left dominant side, Hypertension, and blindness." Interventions were listed for each of the residents' five (5) falls, but none were preventative interventions. The interventions were as follows: On 11/23/2024: "Unwitnessed fall without injury. Neuro checks initiated. Responsible Party (RP), Nurse Practitioner (NP), Director of Nursing (DON) aware." On 5/26/2025: "Fall without apparent injury. Neuro checks initiated. NP and RP notified." On 6/17/2025: "Fall without apparent injury. Neuro checks initiated. NP and RP notified." On 7/7/2025: "Fall without apparent injury. Neuro checks initiated. NP and RP notified." On 8/14/2025: "Fall. NP and RP notified. Sent to ER. Returned with steri-strips... Leave steri-strips in place and allow them to fall off on their own every day and night shift." The care plan lacked documentation of any new or revised interventions to prevent repeat falls after any of these events. Record review of Progress Notes revealed 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. On 9/16/2025 at 12:30 PM, during an interview and record review with the Assistant Director of Nursing (ADON), she confirmed that the facility had not implemented new interventions or revised the resident's care plan following his falls on 11/23/2024, 5/26/2025, 6/17/2025, 7/7/2025, or 8/14/2025. She explained that the care plan should have been revised with new fall prevention strategies after each fall. She stated that the purpose of the care plan was to inform staff about the specific interventions required for each resident. She reported that it was her expectation that new interventions be added and the care plan updated	F0657					

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F0657 SS = G	Continued from page 5 following every fall incident.		F0657				
F0689 SS = G	Record review of the "Admission Record" revealed the facility admitted Resident #1 on 7/31/25 with a diagnosis of Hemiplegia and Hemiparesis following unspecified Cerebrovascular Disease affecting the left dominant side. 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 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. Top of Form Findings Include A review of the facility policy titled, "Fall 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		F0689				

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F0689 SS = G	Continued from page 6 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. 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			F0689			

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F0689 SS = G	Continued from page 7 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.		F0689				