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 12/02/2025

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
F0000	INITIAL COMMENTS The State Agency (SA) conducted complaint investigations (CI)#2667885, CI #2676455, CI #2676511, and CI # 2676615 at the facility from 12/1/25 through 12/2/25. 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 F656 for failure to implement the care plan and F 677 for failure to provide incontinent care to a dependent resident for CI #2667885. There were no deficiencies cited for CI #2676455, CI #2676511, and CI # 2676615 The census at the time of the survey was 126 with a bed capacity of 165 beds.	F0000		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F0656		

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

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 12/02/2025

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
F0656 SS = D	Continued from page 1 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interview, and facility policy review, the facility failed to provide incontinence care in accordance with the resident's care plan for one (1) of 10 residents reviewed for activities of daily living (ADLs). Resident #1 Findings Include: Record review of the facility policy titled " Activities of Daily Living, Supporting" revealed " Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene…Appropriate care and services will be provided for residents who are unable to carry out ADLs independently…in accordance with the plan of care…including appropriate support and assistance with:.. c. elimination (toileting)." Record review of the "Care Plan Report" for Resident #1 revealed "The resident has and ADL self-care performance deficit related to Paraplegia, Hypertension (HTN), C5-C7 spinal cord injury." Interventions included: Toilet use: The resident requires total assistance times two (2) staff for toileting." Further	F0656		

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 12/02/2025

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
F0656 SS = D	Continued from page 2 review of reveled “I have potential for impairment of my skin integrity…related to Paraplegia.” Interventions included: Incontinent care as needed. Observation and interview on 12/2/25 at 8:19 AM, with Certified Nursing Assistant (CNA) #1 of Resident #1’s incontinence pad and brief, she verified the presence of a light brown ring of dried urine and a saturated brief. She agreed that the discoloration and saturation were consistent with urine and likely occurred because the resident had not been changed throughout the night and confirmed that he had not been changed since her shift began at 7:00AM. In an interview with the Director of Nursing (DON) on 12/2/25 at 11:00 AM, she stated that the care plan is used so that staff know what care to provide to the resident. She agreed that facility failed to follow Resident #1’s care plan when they failed to provide incontinent care throughout the night. Record review of the “Admission Record” revealed that the facility admitted Resident #1 on 8/20/25 with a diagnosis of Paraplegia” Record review of “Minimum Data Set Assessment” (MDS) with an Assessment Reference Date (ARD) of 8/29/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated that Resident #1 was cognitively intact. Further review of the MDS revealed that Resident #1 was dependent with toileting.	F0656		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interview, and facility policy review the facility failed to provide Activities of Daily Living (ADL) assistance to a dependent resident related to incontinent care for one (1) of 10 residents reviewed for ADLs. Resident #1. Findings Include: Record review of the facility policy titled “ Activities of Daily Living, Supporting” revealed “ Residents who are unable to carry out activities of	F0677		

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 12/02/2025

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
F0677 SS = D	Continued from page 3 daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene…Appropriate care and services will be provided for residents who are unable to carry out ADLs independently…including appropriate support and assistance with:.. c. elimination (toileting)." On 12/2/25 at 8:15 AM, in an interview with Resident #1, he stated that a Certified Nursing Assistant (CNA) did not come in and change him during the night. He stated that if he is asleep, staff will not check or change him, and would they leave him wet. On 12/2/25 at 8:17 AM, an observation of Resident #1's incontinence pad and brief revealed a light brown colored ring of urine covering the pad and his incontinence brief was saturated with urine and spilling out onto the incontinence pad. On 12/2/25 at 8:19 AM, during an observation and interview with Certified Nursing Assistant (CNA) #1 who was assigned to Resident #1, confirmed that his incontinence pad and brief had a light brown ring of urine and his brief was saturated with urine. CNA #1 confirmed that the discoloration and urine saturation were consistent with the resident not being changed throughout the night. She stated he should have been changed him this morning already but hasn't. On 12/2/25 at 8:25 AM, in an interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), they stated that residents should be checked and provided incontinent care at least every two (2) hours. They agreed that the light brown ring on the incontinence pad and the saturated brief indicated the resident had not been provided incontinent care timely. Record review of the "Admission Record" revealed that the facility admitted Resident #1 on 8/20/25 with a diagnosis of Paraplegia. Record review of "Minimum Data Set Assessment" (MDS) with an Assessment Reference Date (ARD) of 8/29/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicated that Resident #1 was cognitively intact. Further review of the MDS revealed that Resident #1 was dependent with toileting.	F0677		