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 _____	01/31/2019

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

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F 000	INITIAL COMMENTS The State Survey Agency (SA) conducted an annual recertification survey at the facility from 1/29/19 to 1/31/19. During the survey, the SA determined that facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited the regulatory deficiency F645, F656, F677, F679, F686, and F880. At the time of the survey, the census was 172, and the facility held a license for 180 beds.	F 000		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-	F 645		3/14/19

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

Electronically Signed | 03/14/2019

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 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.

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F 645	Continued From page 1 (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an	F 645		

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F 645	Continued From page 2 intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to complete a Pre Admission Screening (PAS) accurately for one (1) of five (5) residents reviewed for PAS, Resident #40. Findings include: Review of the Facility Policy titled, "A1500: Preadmission Screening and Resident Review (PASRR)", Health-related Quality of Life, revealed, "All individuals who are admitted to a Medicaid certified nursing facility must have a Level I PASRR completed to screen for possible mental illness (MI), ..., Individuals who have or are suspected to have Mental Illness (MI), intellectual disability or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination." Review of Medical Diagnosis for Resident #40, revealed Psychotic Disorder with Delusions due to known Physiological Condition with an onset date of 3/3/17, Schizophrenia, onset 1/8/19. Review of the Pre Admission Screening (PAS) dated 3/18/17, revealed a Primary Diagnosis of Schizophrenia. Under the General Pre-Admission Screen And Resident Review (PASARR) - For Nursing Facility Admissions, Part B - Level II Referral Criteria, the question "Person has a diagnosis of a major mental illness?" was answered "No".	F 645	Preparation and submission of the plan of correction by Yazoo City Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirement of state and federal law. 1. On 1/31/19, Social Services Director corrected the Preadmission Screening and Resident Review (PASARR) and sent a Level II Change in Status for Resident #40 to Ascend Management Innovations. Ascend sent an independent contractor to the facility to evaluate Resident #40 on 2/5/19, and the facility received a final determination dated 2/13/19. The determination was that the resident is nursing facility appropriate. 2. From 2/1/19-2/8/19 Social Services Director performed an audit of PASARRs for current residents admitted with in the last ninety (90) days to make sure that PASARRs were entered correctly. Eleven (11) of one hundred and seventy-one (171) residents were noted to need further review. Four (4) residents are short term rehabilitation and do not require PAS, two (2) residents did not require PASARR because it was not required when they	

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F 645	Continued From page 3 On 1/31/19 at 10:03 AM, interview with the Social Services Director (SSD) confirmed that the PAS was not completed correctly and that she spoke with a representative at the Mississippi Division of Medicaid, Office of Mental Health Programs, who stated that the PAS was not entered correctly, and did not trigger a Level II, even though the mental health diagnoses were put in. The SSD stated that a Level II Referral should have triggered initially, therefore the facility policy was not followed. She also stated that it is important that the PAS be completed correctly to determine if a level II is needed because a Level II will show the recommendations from the Department of Mental Health for a resident who has mental health needs. She also stated that the PASARR determines if a resident is appropriate for nursing home placement.	F 645	admitted to the facility, four(4) residents marked incorrectly or not at all, and one(1)resident's Level II not found. Of those five (5) residents, one (1) expired prior to completion of audit, two (2) Ascend sent notice, one (1) level II not needed, and one (1) a significant change was submitted. All residents have the potential to be affected by this deficient practice. 3. On 1/31/19, Social Services department was in-serviced by the Administrator on requirement of validity of information on the PASARR for all newly admitted and/or newly diagnosed residents prior to submission. 4. Beginning 2/11/19, the Administrator will audit three (3) PASARRs from new admissions or newly diagnosed residents with mental impairment per week for the next three (3) months. A report will be submitted by the Administrator to the Quality Assurance Performance Improvement (QAPI) committee for review, and recommendation monthly for three (3) months. Administrator is responsible for monitoring and compliance.	
F 656 SS=E	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	F 656		3/14/19

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F 656	Continued From page 4 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and 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 staff interview, facility policy review, and record review, the facility failed to develop	F 656	1. On 1/31/19, the Assistant Director of Nursing (ADON) immediately updated	

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F 656	Continued From page 5 and implement a comprehensive care plan for Activities for Resident #26, develop a care plan for a new Percutaneous Gastrostomy Tube (PEG) for Resident #57, implement a care plan for Decubitus Care for Resident #123, and Respiratory Care for Residents #42, and #44, for five (5) of 33 residents reviewed for Care Plans. Findings Include: Review of the facility's policy, "Care Plans, Comprehensive Person Centered", 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. Resident #57: Record review revealed Resident #57 returned to the facility from the hospital on 1/12/19, with a new Percutaneous Gastrostomy Tube (PEG). Review of Resident #57's record revealed there was not a care plan related to the new PEG tube for Resident #57. On 1/30/19 at 2:24 PM, interview with the Minimum Data Set (MDS) Nurse revealed that Resident #57 returned from the hospital on 1/12/19, with a new Peg tube. The MDS Nurse stated the admitting nurse should have written a care plan for the new Peg tube when the resident returned from the hospital, but did not. She stated that the resident returned on the weekend and a PRN (as needed) nurse failed to initiate the care plan. The MDS Nurse stated it should have been caught in the Interdisciplinary Team (IDT)	F 656	Resident # 57's care plan to include Percutaneous Gastrostomy Tube (PEG) goals and interventions. On 1/31/19, Resident #26's Evaluation and care plan was reviewed and revised as indicated to reflect resident's individualized activity program by the Activity Director. On 1/29/19, Residents #42 and #44's respective care plans were updated to include storage protocols for when nebulizer is not in use by ADON. On 1/31/19, Resident #123's care plan was checked to ensure interventions are in place for wounds to correspond with physician's orders by ADON. 2.From 2/1/19 through 2/8/19 an audit was performed by the Minimum Data Set (MDS) nurse of resident's respective care plans in regards to PEGs, Activity programs, nebulizer storage, and review of physician orders related to wound care, to ensure resident's current care needs were reflected: those found not to be accurate were updated immediately. All residents have the potential to be affected by this deficient practice. 3.In-services began on 2/1/19 by Staff Development Coordinator (SDC) with interdisciplinary team (IDT) members that develop/revise care plans ensuring accuracy on care plans including goals, interventions, and implementations. 4. Beginning 2/11/19, the Director of Nursing (DON)/ADON will audit three (3) residents care plans and monitor direct care staff to validate care plan is being	

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F 656	Continued From page 6 meeting on Monday morning that the care plan was not initiated, but it wasn't. The MDS Nurse stated the care plan should have been entered into the computer at that time. On 1/30/19 at 3:56 PM, an interview with the Director of Nursing (DON) revealed the nurse who received the resident back from the hospital should have developed a new care plan for Resident #57's PEG tube, with new interventions for care. She stated the nurse failed to develop a new care plan as needed. Resident #26 Record review of Resident #26's comprehensive care plan, revised 10/9/18, revealed the resident needed encouragement/assistance to attend/observe activities for stimulation/socialization. The interventions included to invite/assist and encourage resident to attend/observe activities for socialization/stimulation. Record review of Resident #26's individual activity participation record for the month of January 2019, revealed no activities were provided to, or attended by Resident #26. On 1/29/19 at 11:13 AM, during the initial tour, an interview with Resident #26, (with a Brief Interview of Mental Status (BIMS) score of 15), revealed the resident has not been getting out of bed because the staff took her wheelchair away from her and she can not go to activities. Resident #26 revealed she does not remember being asked to come to activities and does not remember anyone bringing activities to her room. She wanted to go to activities.	F 656	updated and implemented. Audits and observations will be conducted weekly for four (4) weeks, then monthly for two (2) months. The ADON will submit a report to Quality Assurance and Performance Improvement (QAPI) team for review and recommendations monthly for three (3) months. The DON is responsible for monitoring and compliance.	

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F 656	Continued From page 7 On 1/30/19 at 11:07 AM, an interview with the Activity Director (AD) confirmed Resident #26's activity log sheet for the month of January revealed the resident did not have any activities marked as attended or provided. The AD revealed she did not realize Resident #26 had not attended any activities during January. The AD revealed Resident #26 just likes to visit with staff and sit in her room. On 1/30/19 3:15 PM, observation of Resident #26 revealed her sitting in her room in a Ger-chair. The Director of Nursing (DON) entered the room and told the resident that there was plenty of Ger-chairs and she should be able to go to activities and get up any time she wants. The DON confirmed the care plan was not followed for Resident #26 to encourage and assist the resident to activities. On 1/31/19 at 1:45 PM, an interview with AD revealed she would attempt to get the resident to go more often and if she will not go to the activity she will provide in room activities. The AD revealed the care plan instructed staff to provide activities to Resident #26, and they had not provided activities like they should have, per care plan. Resident #42 Review of Resident #42's current care plan, dated 11/5/18, revealed Resident #42 had a care plan for Nebulizer treatments. It did not address how the equipment would be stored when not in use, only to follow the facility protocol. Observation on 1/29/19 at 10:45 AM, revealed a Nebulizer mask laying on Resident #42's bedside	F 656		

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F 656	Continued From page 8 table, not in a bag. Further observation on 01/30/19 09:18 AM, revealed a Nebulizer mask laying on the bed side table under the resident's cap. The mask was not in a bag or stored. Review of the current January 2019 Physician's orders revealed Nebulizer treatments were ordered every 12 hours and every four (4) hours as needed. Oxygen was ordered at two (2) liters as needed. Observation and interview with the RN Supervisor, on 1/30/19 at 12:08 PM, confirmed the resident's nebulizer mask was laying on the bedside table not stored properly in a bag. On 1/30/19 at 04:17 PM, interview with the Director of Nursing (DON) revealed all respiratory equipment should be in a plastic bag and dated. She confirmed the respiratory equipment storage should be specified on the care plan. Resident #44 Review of Resident #44's current care plan revealed to change nebulizer equipment as ordered/per facility protocol. The care plan does not address storage of the nebulizer mask when not in use. On 1/29/19 at 10:30 AM, observation revealed a nebulizer mask laying in floor beside the bedside table in Resident #44's room. The nebulizer mask was not in a bag or stored properly. Resident #123 Review of the current Care Plan, for Resident #123, revealed interventions for the Unstageable Pressure Ulcer to the Left Heel, which included:	F 656		

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F 656	Continued From page 9 Follow treatment orders as prescribed to left heel (9/30/18), with the last current date of 11/7/18. Review of the Physician Order dated 11/7/2018, revealed: Left heel. Cleanse Unstageable Pressure Ulcer with normal saline every day shift, pat dry, paint with betadine, and wrap with kerlix every day shift. During an observation and interview, on 1/31/19 at 9:09 AM, Licensed Practical Nurse (LPN) #1 performed wound care to the Left Heel Pressure Ulcer for Resident #123. LPN #1 cleaned the left heel with normal saline, patted dry, applied a 4 x 4 gauze to the wound bed and wrapped the left foot with kerlix. The nurse stated that betadine should not be used on the left heel. The order dated 11/7/2018, was reviewed with the nurse upon leaving the room. The nurse confirmed the correct order in the computer and stated that betadine should be applied per Medical Doctor (MD) orders, and that she had not performed it correctly, per orders and care plan. On 1/31/19 at 2:10 PM, interview with the Director of Nursing (DON), confirmed that the nurse did not follow the Care Plan for the treatment of the left heel, due to not using the Betadine.	F 656		
F 677 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, staff interview, and facility	F 677	1. On 1/30/19, Licensed Practical Nurse	3/14/19

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F 677	Continued From page 10 policy review, the facility failed to provide oral care to a dependent resident, for one (1) of seven (7) residents reviewed for oral care, Resident #368. Findings include: Record Review of the facility's "Mouth Care" policy, revised February 2018, revealed: The purposes of this procedure are to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent oral infection. The facility did not have a policy addressing the timing or frequency of oral care. Record review of the Nurse Aide's Information Sheet revealed no instructions addressing oral care for Resident #368, and under the title of "grooming", the resident required total care. On 01/30/19 at 8:22 AM, an observation of tracheostomy care by the Respiratory Therapist (RT) revealed Resident #368's mouth and tongue had a white, caked up, rough matter on the tip of his tongue. Resident #368 began shutting his eyes very tightly, moving his head side to side and reaching up and grabbing his tongue. Resident #368 was nonverbal. Resident also had a white substance starting at the left corner of his mouth and continued down under his chin. The RT asked Resident #368 if his tongue was itching, the Resident opened his eyes and continued to pull and rub on his tongue. On 01/30/19 at 8:45 AM, an interview with the RT confirmed the resident's tongue had a white/yellowish, dry, crusty, rough coating on the tip of his tongue.	F 677	#1 (LPN) immediately performed oral care for Resident #368. Assistant Director of Nursing #1 (ADON)updated Resident #368's care plan and care card to reflect oral care needs for resident. 2. From 2/1/19 to 2/8/19 ADON audited current residents' care plans and care cards to ensure oral care needs were reflected. Care plans that did not reflect current oral care needs were immediately corrected. All residents have the potential to be affected by this deficient practice. 3. In-services began on 2/1/19, by Staff Development Coordinator (SDC), with licensed nurses and Certified Nurses Assistants (CNA)staff on ensuring oral care interventions are recorded on the care plan and care card. Return demonstrations were initiated for CNAs by SDC on 2/1/19 for oral care being provided per care plan and care cards. 4. Beginning 2/4/19, Registered Nurse (RN) Supervisors will monitor oral care being performed on three (3) residents per day per unit daily for one (1) week, weekly for one (1) month, and monthly for three (3) months. A report will be submitted to the Quality Assurance Performance Improvement (QAPI) committee by the DON for review and recommendation monthly for three (3) months. The DON is responsible for monitoring and compliance.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 11 On 01/30/19 at 8:55 AM, an interview with Registered Nurse (RN) #1/Supervisor, confirmed the resident's tongue needed oral care and stated the nurse and CNA are supposed to provide oral care as needed. RN #1 stated the oral care is not scheduled, but as needed. RN #1 stated that the resident did not get the oral care he needed. On 1/30/19 at 2:15 PM, an interview with the Director of Nursing (DON), revealed there is no scheduled time to perform oral care for Resident # 368. She stated nurses and CNA's perform oral care on an as needed basis. She stated the resident's mouths should be assessed and oral care should be provided when needed.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, record review, and facility policy review, the facility to provide activities that met the needs and interests of the resident for one (1) of 33 residents reviewed for Activities, Resident #26. Findings include	F 679	1. On 1/31/19, Activity Director (AD) met with Resident #26 and completed a new evaluation updating resident's activity preferences. On 1/31/09, the Administrator educated the AD on the importance of completing evaluation, completing documentation in a timely	3/14/19

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	255146	A. BUILDING _____ B. WING _____	01/31/2019

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F 679	Continued From page 12 Review of the facility's "Activity Programs" policy, dated August 2006, revealed the activity programs designed to meet the needs of each resident are available on a daily basis. The activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs. Record review of Resident #26's individual activity participation record for the month of January 2019, revealed no activities were attended or provided. Record review of Resident #26's comprehensive care plan revealed the resident needed encouragement/assistance to attend/observe activities for stimulation/socialization. The interventions include to invite/assist and encourage resident to attend/observe activities for socialization/stimulation. On 1/29/19 at 11:13 AM, during the initial tour, an interview with Resident #26 revealed the resident had not been getting out of bed because the staff took her wheelchair away from her and she can not go to activities. Resident #26 revealed she does not remember being asked to come to activities and does not remember anyone bringing activities to her room. Resident #26 had a Brief Interview of Mental Status score of 15, which indicated she had no cognitive impairment. On 1/29/19 at 11:35 AM, an interview with the Registered Nurse Supervisor (RN) #1, revealed Resident #26 was no longer able to sit in a wheel chair due to poor trunk control, and when she gets up, it is in a Ger-chair.	F 679	manner and ensuring resident are invited to participate in planned activities. 2. From 2/1/19 through 2/8/19, the AD and Minimum Data Set (MDS) nurse audited current resident's clinical records to ensure that activity evaluations were complete and care plans reflected the individual resident's activity program preferences. All residents have the potential to be affected by this deficient practice. 3. Beginning on 2/1/19, The Staff Development Coordinator (SDC) began in-serving staff in regards to inviting residents to the daily activities offered. All new residents are to have their initial activity evaluation completed on or by the Assessment Reference Date (ARD) for admission. 4. Beginning on 2/11/19, the MDS nurse will audit (2) resident's clinical records per week for four (4) weeks, then monthly for three (3) months to ensure activity evaluation are completed timely and care plans reflect resident's activity preferences. Beginning 2/11/19, social services department will interview five(5)residents on if they wish to participate in activities, and if they answer yes, are they being asked to go. This audit will be performed on five (5) residents weekly for four (4) weeks and five (5) residents monthly for two (2) months. A report will be submitted by the MDS nurse to the Quality Assurance and Performance Improvement (QAPI)	

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F 679	Continued From page 13 On 1/29/19 at 11: 45 AM, an interview with Resident #26 revealed she had been up in a Ger-chair a few times since they took her wheel chair away, which was about two (2) months ago, and that she had to share a Ger-chair with other residents, so the Ger-chair was not available very often. On 1/30/19 at 11:07 AM, an interview with the Activity Director (AD) and review of Resident #26's activity log sheet for the month of January, revealed the resident did not attend or have activities offered this month. The AD stated the resident gets up in a wheelchair and does not like to come to many activities. On 1/30/19 at 11:30 AM, an interview with Licensed Practical Nurse (LPN) #2 revealed Resident # 26 gets up in her high-back wheel chair and goes to therapy but does not go to many activities. LPN #2 revealed she can only really remember her going to activities maybe once or twice. On 1/30/19 at 2:30 PM, an interview with the Director of Nursing revealed there are enough Ger-chairs that residents should be able to get up and attend activities any time they wanted to. The facility had plenty of Ger-chairs and she would educate the staff on the Ger-chairs. On 1/31/19 at 2:40 PM, an interview with the Administrator revealed the staff should have made arrangements to make sure Resident #26 was able to go to activities. The Administrator stated there were plenty of Ger-chairs at the facility and as soon as she was made aware of the problem, they provided Resident #26 with a Ger-chair of her own.	F 679	committee for revie4w and recommendation monthly for three months. The MDS nurse is responsible for monitoring and compliance.	

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F 679	Continued From page 14 On 01/31/19 at 1:45 PM, an interview with the AD revealed staff had not provided activities to Resident #26 like they should have.	F 679		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to provide treatment for a Decubitus ulcer as ordered by the physician for one (1) of three (3) residents observed for Decubitus care, Resident #123. Findings include: Review of the facility's Pressure Ulcer Prevention Program, Skin and Wound Care policy, revised 7/2018, revealed: Treatment will be initiated per physician orders. Review of Resident #123's Physician Order,	F 686	1. On 1/31/19, the Licensed Practical Nurse (LPN) #1 performed the wound care procedure again on resident #123 under direct observation of the Staff Development Coordinator (SDC) Registered Nurse in accordance with the physician's orders. On 1/31/19, LPN#1 was educated on following physician orders and wound care procedures by the Assistant Director of Nursing (ADON). 2.Begining 2/1/19 through 2/8/19, an audit was performed by the ADON on the sixty (60) wound orders for current residents to ensure physician's orders are accurate	3/14/19

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F 686	Continued From page 15 dated 11/7/2018,, revealed: "Left heel. Cleanse Unstageable Pressure Ulcer with normal saline every day shift, pat dry, paint with betadine, and wrap with kerlix every day shift". During an observation and interview, on 1/31/19 at 09:09 AM, Licensed Practical Nurse (LPN) #1, performed wound care to the Left Heel Pressure Ulcer for Resident #123. LPN #1 cleaned the left heel with normal saline, patted dry, applied a 4 x 4 gauze to wound bed, and wrapped the left foot with kerlix. The nurse stated that Betadine should not be used on the left heel. The order dated 11/7/2018, was reviewed with the nurse upon leaving the room. The nurse confirmed the correct order in the computer and stated that Betadine should be applied per Medical Doctor (MD) orders, and that she had not performed the treatment correctly. On 01/31/19 at 2:10 PM, an interview with the Director of Nursing (DON), confirmed that the MD orders should be followed and a potential outcome of not following the orders could be worsening of the wound.	F 686	with no negative findings. All residents with wounds have the potential to be affected by this deficient practice. 3. In services began on 2/1/19, by SDC with nursing staff who input orders in the system, in regards to ensuring that physician's orders are read, followed, and that wound care supplies are stored in accordance to facility policy. All newly hired licensed nursing staff who may transcribe physician orders receive this training as part of their orientation process. 4. Beginning 2/11/19, the Director of Nursing (DON), ADON or SDC will perform wound care observation on two (2) residents daily for one (1) week, two (2) residents weekly for four (4) weeks, and two (2) residents monthly for three (3) months to ensure wound care is being performed according to physician's orders. A report will be submitted to the Quality assurance Performance Improvement (QAPI) committee by the DON for review and recommendation monthly for three (3) months. The DON is responsible for monitoring and compliance.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		3/14/19

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F 880	Continued From page 16 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

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F 880	Continued From page 17 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and facility policy review, the facility failed to store respiratory equipment per facility policy, in a clean and sanitary manner for two (2) of four (4) residents observed for oxygen therapy, Residents #42, and #44. Findings include: Review of the policy, "Departmental (Respiratory Therapy)-Prevention of Infection", revised 2011, revealed under the section of "Infection control considerations related to medication nebulizers/continuous aerosol": Store in a plastic bag, marked with date and resident's name, between uses.	F 880	Resident #'s 42 and #44 respiratory supplies were replaced on 1/30/19 by the Assistant Director of Nursing (ADON). 2. An audit was conducted on 2/1/19 by the ADON on residents with physician orders for nebulizer treatments to ensure nebulizer equipment was stored in accordance to facility policy: equipment found improperly stored was replaced at that time. Residents using oxygen/respiratory equipment have the potential to be affected by this deficient practice. 3. On 2/1/19, the Staff Development Coordinator (SDC) began in servicing	

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F 880	Continued From page 18 Review of a policy, "Administering Medications through a small volume (handheld) Nebulizer", revised 2010, revealed: When equipment is completely dry, store in a plastic bag with the resident's name and date on it. Resident #42 Observation on 1/29/19 at 10:45 AM, revealed the Nebulizer mask laying on the bedside table, not covered in a bag. Observation on 1/30/19 at 9:18 AM, revealed Resident #42's Nebulizer mask was laying on the bed side table, under the resident's cap, and the mask was not in a bag. On 1/30/19 at 12:08 PM, Observation and interview with the RN Supervisor confirmed the resident's nebulizer mask was laying on the bedside table not in a bag. On 1/30/19 at 4:17 PM, interview with the Director of Nursing (DON) revealed all respiratory equipment should be in a plastic bag and dated. She stated they are supposed to be changed every Sunday. She stated it is the responsibility of the nurses to do this. She stated this is an infection control problem. Resident #44 On 1/29/19 at 10:30 AM, observation revealed the nebulizer mask laying in the floor beside Resident #44's bedside table. On 1/30/19 at 12:08 PM, observation and interview with the RN Supervision and Resident #44, revealed the resident's nebulizer mask was	F 880	nursing staff in regards to administering medication through a small volume nebulizer, cleaning and storage of equipment. Beginning 2/1/19, licensed nursing staff responsible for administering nebulizer treatments performed return demonstration in direct observation of the Director of Nursing (DON), ADON, or SDC, of nebulizer treatment and storage equipment following treatment. All newly hired licensed nursing staff who may give nebulizer treatments have this training and return demonstration as part of their orientation process. 4. On 2/1/19, the DON and/or ADON began monitoring three (3) nebulizer treatment including storage one (1) daily for one (1) week, three (3) nebulizer treatment storage including weekly for one (1) month, and three (3) nebulizer treatment storage including monthly for three (3) months. A report will be submitted to the Quality Assurance Performance Improvement (QAPI) committee by the DON for review and recommendation monthly for three (3) months. The DON is responsible for monitoring and compliance.	

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F 880	Continued From page 19 in a bag. Interview with the resident confirmed his nebulizer mask had not been in a bag earlier.	F 880		

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	255146	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**01/30/2019**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order	K 923		3/14/19

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

Electronically Signed | 03/14/2019

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 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.

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K 923	Continued From page 1 of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to provide secured "free standing cylinders" to be properly chained or supported in a proper cylinder stand or cart as required by NFPA 101 Chapter 19 section 19.3.2.4, NFPA 101 Chapter 8 section 8.7.3 and NFPA 99 Chapter 11 section 11.6.2.3. This deficient practice has the potential of affecting one (1) of five (5) smoke compartments and (16) of (172) residents in the facility on the day. Findings include: On January 30, 2019 at 10:45 AM, observation revealed two (2) unsecured, oxygen cylinders located outside the Medicine Room of the Annex Side nurses station. These oxygen cylinders were full of oxygen and had the potential of being knocked over. The finding was acknowledged by the Administrator and Maintenance Supervisor during the exit interview on January 30, 2019.	K 923	1. On 1/30/19 the Maintenance Director immediately removed the tanks and placed them securely in the indicated holding area. 2. On 1/31/19 Maintenance Director ordered a small six (6) oxygen tank holder for each nurse's station. Holder have been delivered and were placed at the nurse's stations on 3/4/19. 3. In-services were initiated with licensed nurses on 2/1/19 by the Staff Development Coordinator (SDC) on proper storage of oxygen tanks. 4. Beginning 2/4/19 Maintenance Director will monitor all three (3) nurse's stations and the indicated storage area to ensure proper placement and storage of oxygen tanks weekly for on (1) month, and monthly for three (3) months. A report will be submitted to the QAPI committee by the Maintenance Director for review and recommendation monthly for three (3) months. The Administrator is responsible for monitoring and compliance.	

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 03/14/2019

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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
E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 1/30/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

Electronically Signed | 03/14/2019

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 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.