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	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yazoo City Rehabilitation and Healthcare Center	925 Calhoun Avenue Yazoo City, MS 39194

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47158 Based on observation, staff interview, record review and facility policy review, the facility failed to monitor frequently and have provided increased supervision to a resident who was identified by the facility as being at high risk for wandering for one (1) of seven (7) residents at risk. (Resident # 73). Findings Include: Record review of the facility policy titled, Wander Management Monitoring System and Resident Elopement Protocol, with a revision date of 1/17/18 revealed, Purpose: To monitor safety of residents at risk for elopement . Policy: It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible . Record review of facility investigation revealed that on 11/2/24 at 5:00 PM, the Administrator (ADM) was contacted by the Director of Nursing (DON) notifying her that Resident #73 had walked out the front door of the facility and was returned to the facility at approximately 5:30 PM. Resident #73 stated to the nurse that some people came in the front door of the facility so he went out the door to go visit his friends. Upon returning the resident inside the facility, it was noted that Resident #73's wander guard bracelet did not alarm. Investigation revealed that the wander guard bracelet appeared to have malfunctioned. Maintenance arrived and tested all the doors in the facility and the wander blue system. Resident #73's wander guard was replaced, and he was placed on one-on-one monitoring. The malfunctioning of the bracelet was noted to be sudden, and the previous checks did not reveal any issues. Record review of elopement assessment dated [DATE], revealed a score of 25, indicating Resident #7 was high risk for wandering, but did not indicate that the resident required more frequent monitoring. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed Practical Nurse (LPN) #1 was interviewed on 11/12/24 at 11:00 AM and stated that she last saw Resident #73 on 11/2/24 around 12:45 PM, during lunch. She stated that Resident #73 walks around the facility, spending time on the first and second floors, often sitting on the couch on the first floor close to the door. LPN #1 reported that earlier in the day, she had checked Resident #73's wander guard by testing it near the front door, where it triggered the alarm, so she knew the wander guard had worked earlier in the day. LPN #1 confirmed that she did not look for the resident again until around 4:15 PM when she needed to check his blood sugar. LPN #1 stated that the facility doesn ' t have to document on the medical record that they have seen the resident throughout the day other than when it is time for his blood sugar checks at mealtimes or medications to be given. An interview with Certified Nursing Assistant (CNA) #1 on 11/12/24 at 11:15 AM, confirmed that Resident #73 walks around the facility, spending time on the first and second floors and confirmed that she did not attempt to locate the resident before her shift ended at 3:00 PM. An interview on 11/13/24 at 8:30 AM with the Administrator confirmed that staff failing to check on the location of Resident #73, who was at high risk for wandering, from 12:45 PM until 4:15 PM could place him at risk of accidents and/or injury. Record review of the Admission Record revealed the facility admitted Resident # 73 on 7/12/2024 with diagnoses that included Cognitive Communication Deficient. Record review of the Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 10/19/24 revealed a Brief Interview of Mental Status score of 9, indicating that Resident #73 has moderate cognitive impairment.