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	04/10/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review, staff interview, and facility policy review the facility failed to ensure the physician or nurse practitioner was notified of an omitted medication for one (1) of three (3) residents reviewed for medication errors. Resident #2.Findings Included:Record review of the facility policy, titled Condition & Medical Doctor (MD)-Family Notification, revealed Purpose: To ensure that resident's family and/or legal representative and physician are notified of resident changes that fall under the following categories.A need to significantly alter treatment.Record review of Order Summary Report for Resident #2 revealed an order for Lantus SoloStar Subcutaneous Solution Pen-Injector 100 units/milliliter. Inject 10 units subcutaneously at bedtime with an order date of 1/16/26.Record review of the January 2026 Medication Administration Record (MAR) for Resident #2 revealed that on 1/16/26, 1/17/26, and 1/18/26, the resident did not receive the ordered dose of insulin.Record review of Progress Notes dated 1/16/26, for Resident #2, revealed documentation that insulin was pending pharmacy. There was no further documentation explaining the omission of the medication.Further record review of Progress Notes dated 1/16/26 through 1/18/26, for Resident #2, revealed no documentation that the Physician or Nurse Practitioner was notified that the insulin was not administered as ordered.Interview with the Director of Nursing (DON) on 4/10/26, at 8:35 AM, she verified that there was no documentation that the provider was notified that Resident #2 did not receive the ordered insulin. She agreed that failure to notify the provider prevented the opportunity for the provider to assess the resident's condition and alter treatment as necessary.Record review of the admission Record revealed that the facility admitted Resident #2 on 1/16/26 with a diagnosis of Type two (2) Diabetes Mellitus with Hyperglycemia.

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.

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

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F 0628 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and resident representative interview, and facility policy review, the facility failed to implement an effective discharge planning process to ensure necessary durable medical equipment (DME) was arranged and received prior to discharge for one (1) of three (3) residents reviewed, Resident #1.The facility failed to ensure Resident #1, who required tracheostomy care including suctioning and nebulizer treatments, was discharged with necessary respiratory equipment. The resident was discharged home on 2/23/26 without a suction machine or nebulizer, resulting in the need for emergency medical services (EMS) intervention and subsequent hospitalization due to unsafe discharge conditions.The facility's failure to ensure a safe discharge process placed Resident #1 in a situation that was likely to cause serious harm, injury, impairment, or death.The State Agency (SA) identified an Immediate Jeopardy (IJ) that began on 2/23/26 when the facility failed to ensure necessary respiratory equipment was in place prior to discharge, resulting in the resident being unable to safely maintain airway clearance and requiring EMS intervention and hospitalization.IJ existed at: 42 CFR 483.15(c)(2) Discharge Process (F628)- Scope/Severity J.On 4/9/26 at 10:32 AM, the SA notified the Administrator of the Immediate Jeopardy and provided the facility with the IJ template. The facility submitted an acceptable Removal Plan on 4/9/26, in which they alleged all corrective actions were completed on 4/9/26 and the IJ was removed on 4/10/26.The SA validated the Removal Plan on 4/10/26 through record review and staff interview and determined the IJ was removed on 4/10/26, prior to exit. Therefore, the scope and severity for F628 was lowered from a J to a D while the facility continues to monitor systemic changes to ensure sustained compliance.Findings include:Record review of Facility Protocol: Safe Discharge Process, revealed It is the protocol of the facility to ensure that all residents are discharged in a safe and coordinated manner, with all necessary services, equipment, and supports in place prior to discharge.5. Durable Medical Equipment (DME): All required equipment must be ordered, coordinated, and verified as delivered and functional prior to discharge. Discharge will not occur until confirmed.Record review of the admission Record revealed that the facility admitted Resident #1 on 12/2/25 with diagnoses including Acute and Chronic Respiratory Failure with Hypoxia, Chronic Obstructive Pulmonary Disease, and Tracheostomy Status. Resident was discharged home on 2/23/26.A record review of Order Summary revealed Resident #1 required tracheostomy suctioning every four (4) hours and as needed and inhalation therapy via (by) nebulizer every six (6) hours with orders dated 12/2/25.Record review of a Psychosocial Note dated 1/29/26, revealed Social Services (SS) arranged discharge with home health services and durable medical equipment including a hospital bed, wheelchair, and bedside commode. The record lacked evidence that a suction machine or nebulizer was arranged or verified prior to discharge.Record review of hospital medical records dated 2/24/26, revealed Resident #1 presented to the hospital via emergency medical service (EMS) due to not having correct supplies for tracheostomy care at home and was admitted because it was unsafe to remain at home without necessary equipment.Telephone interview with Resident #1's Representative (RR) on 4/8/26 at 1:00 PM, revealed the resident did not receive a nebulizer or suction equipment at discharge, EMS had to be called to suction the resident, and the resident was hospitalized until equipment was obtained.Interview with Social Services (SS) on 4/8/26 at 3:15 PM, revealed she arranged DME and notified home health of tracheostomy needs but believed all equipment had been delivered and denied knowledge that suction or nebulizer equipment was not received.Telephone interview with Home Health Nurse #1 (HHN) on 4/8/26 at 4:30 PM, revealed the facility notified the agency of tracheostomy supplies and nebulizer needs but did not include a suction machine and confirmed that it was the facility's responsibility to ensure DME was ordered and delivered prior to discharge.Telephone interview with HHN #2 on 4/9/26 at 8:05 AM, revealed she was notified by the (continued on next page)

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F 0628 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RR that required equipment had not been delivered and EMS was required to suction the resident, and she instructed the resident be sent to the hospital until equipment was received.Follow-up interview with SS on 4/9/26 at 8:45 AM, revealed she did not arrange for a suction machine or nebulizer and did not verify delivery of all required equipment prior to discharge, as she believed home health would provide those items.Interview with the Administrator on 4/9/26 at 8:50 AM, revealed it was the expectation that all required equipment be in place prior to discharge and acknowledged failure to provide necessary equipment could result in respiratory distress and/or death.Removal PlanThe facility failed to ensure an effective and safe discharge process for Resident #1 by not coordinating and verifying delivery of required DME, including suction equipment and a nebulizer machine, prior to discharge on [DATE]. This resulted in the resident being discharged home without necessary equipment to meet post-discharge needs.1. On 4/9/26, at approximately 10:30 AM, the Administrator developed a Discharge Durable Medical Equipment Verification Checklist to address resident-specific durable medical equipment requirements. This checklist encompasses nursing and therapy assessments, obtaining physician orders, confirmation of equipment delivery dates, receipt verification, home health referral and acceptance, education for family and responsible parties, transportation arrangements, and comprehensive discharge instructions.2. On 4/9/2026 at 11:46 AM, Staff Development Coordinator (SDC) contacted Ambulance service personnel to request medical records from 2/24/2026.3. On 4/9/2026 at approximately 11:48 AM, Medical Records contacted the hospital to request Resident #1 hospital records for 2/24/2026.4. On 4/9/2026 at approximately 12:15 PM, Social Services (SS) contact Resident #1 Responsible Party (RP) to verify Resident #1 wellbeing and ensure all Durable Medical Equipment was received. Resident #1 Responsible Party (RP) stated they had everything they needed, and Resident # 1 was doing fine.5. On 4/9/2026 at approximately 12:45 PM, Resident #1 medical records were received from the hospital and verified all necessary Durable Medical Equipment was not previously provided confirming allegation.6. On 4/9/2026 at approximately 1:30 PM the Staff Development Coordinator (SDC) conducted a one-to-one training with Social Services (SS) to ensure the discharge process is followed confirming all Durable Medical Equipment is not only ordered but received prior to discharged . Services are confirmed with the accepting provider, and documentation is completed in the medical records.7. On 4/9/2026 at approximately 1:46 PM, Quality Assurance Improvement Committee was held including Administrator, Asst. Administrator, Medical Director, Staff Development, Social Services Director, Infection Preventionist, Social Services Assistant and Director of Nursing Facility to discuss previous identified gap in the discharge process as it relates to ensuring all Durable Medical Equipment was ordered and received at the time of discharge and to include the systemic change utilizing mandatory discharge check list. 8. On 4/9/2026 at approximately 2:15 PM, in servicing was with all licensed nurses, social services, therapy and leadership staff on discharge planning requirements, including the coordination of all necessary Durable Medical Equipment prior to discharge to home was provided by Voice Friend via phone. 9. On 4/9/26, at approximately 2:15 PM, the Staff Development Coordinator provided education to all licensed nurses to ensure a hard stop is in place so that no resident is discharged without following the discharge checklist.10. On 4/9/2026, at approximately 2:24 PM, Human Resources will place a copy of the discharge planning check list in all new hire licensed nurses' orientation packets for completion.11. On 4/9/2026, at approximately 3:00 PM, a 100% audit of all residents discharged home from 2/23/26-4/09/2026 was completed by the Staff Development Coordinator (SDC) to ensure all Durable Medical Equipment was received as ordered. The results revealed no identified gaps.12. Facility alleged that all activities to remove the Immediate Jeopardy were completed as of 04/09/2026 and the Immediate Jeopardy was removed 04/10/2026. Validation:The SA validated on 4/10/26, through interview and record review that all corrective actions had been implemented as of 4/9/26, and the IJ was removed as of 4/10/26 prior to exit.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on record review, staff interview, and facility policy review the facility failed to administer ordered Lantus insulin for three (3) consecutive days for one (1) of three (3) resident reviewed for medication errors. Resident #2 Findings Included:Record review of the facility policy titled, Medication Administration reviewed and revised 3/5/26 revealed 4. Medications are administered according to prescriber orders and within the ordered time frames.Record review of Order Summary Report for Resident #2 revealed an order for Lantus SoloStar Subcutaneous Solution Pen-Injector 100 units/milliliter. Inject 10 units subcutaneously at bedtime with an order date of 1/16/26.Record review of the January 2026 Medication Administration Record (MAR) for Resident #2 revealed that on 1/16/26, 1/17/26, and 1/18/26, the resident did not receive the ordered dose of insulin.Record review of Progress Notes dated 1/16/26, for Resident #2, revealed Type: Orders - Administration Note, Note Text: Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML Inject 10 unit subcutaneously at bedtime related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65) - Pending pharmacy. There was no further documentation regarding why the medication was not given.Record review of Consolidated Delivery Sheets dated 1/16/26 revealed that Lantus Solostar 100 units/3ml was delivered to the facility on 1/16/26 and was signed for by two (2) nurses.Telephone interview with Licensed Practical Nurse (LPN) #1 on 4/09/26, at 4:00 PM, she stated she did not recall the resident or the medication and did not know what occurred.Interview with the Director of Nursing (DON) on 4/10/26, at 8:35 AM, she verified that Resident #2's insulin was not given on 1/16/26 through 1/18/26. She verified that the 1/16/26 progress note indicated that the medication was pending pharmacy, which indicated that the staff had not received the medication. She further explained that the Consolidated Delivery Sheets verified that the medication was sent on 1/16/26 from the pharmacy, but the nurses who signed for the medication worked a different unit and it was possible that it was not taken to the unit where Resident #2 resided. She agreed that failure to administer the medication as ordered could result in adverse outcomes such as hyperglycemia.Record review of the admission Record revealed that the facility admitted Resident #2 on 1/16/26 with a diagnosis of Type two (2) Diabetes Mellitus with Hyperglycemia.