

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/07/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/24/2025
NAME OF PROVIDER OR SUPPLIER YALOBUSHA COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 630 SOUTH MAIN STREET WATER VALLEY, MS 38965		
(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 000	INITIAL COMMENTS The State Agency (SA) conducted two (2) Complaint Investigations (CI MS #27341 and CI MS #27548) at the facility on 2/24/25. During the survey, the SA determined the facility was not in compliance with the Medicare and Medicaid requirements for participation regarding CI MS #27548 related to Accidents and Hazards and Care Plans and cited F 656 and F 689. The facility was found to be in compliance for CI MS #27341 regarding Activities of Daily living, falls nutrition, Quality of Care and treatment, personal property, and dignity with no deficiencies cited.	F 000			
F 656 SS=G	At the time of survey the facility had a census of 81 residents and was licensed for 122 beds. 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	F 656		3/17/25	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/06/2025

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 656	Continued From page 1 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. §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 staff interview, record review, and facility policy review, the facility failed to develop a care plan for the behavior of wandering for one (1) of four (4) resident care plans reviewed. Resident #1, who had documented wandering behaviors, wandered into a resident room and hit a resident, resulting in that resident sustain a nasal bone fracture. Findings include: Review of the facility policy titled, "Care Plan	F 656	Resident #1's comprehensive care plan was developed for wandering on February 25, 2024. All residents have the potential to be affected. A 100% audit of all comprehensive care plans was conducted on February 24, 2025, to ensure all residents with behaviors have a care plan developed and updated. An In-service for all nursing		

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F 656	Continued From page 2 Policy,"with no revision date revealed, the facility shall develop a comprehensive care plan. ... The comprehensive care plan shall include but not limited to measurable goals with objectives that are measurable to meet the residents, medical, nursing, mental and psychosocial needs and shall be person-centered. ... Record review of Resident #1's care plans revealed there was not a care plan regarding wandering. Record review of Resident #1's Section C of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/18/24 revealed a Brief Interview for Mental Status (BIMS) score was 4, indicating the resident was severely cognitively impaired. Section E0900: Wandering presence and frequency: coded 3.) Behavior of this type occurs daily. On 2/24/25 at 10:20 AM, during an interview with the Director of Nursing (DON) regarding a facility reported incident related to Resident #1 and Resident #2, she stated it was determined through staff and resident interviews, and investigation that Resident #1 wandered into Resident # 2's room on 1/5/25 and hit Resident #2 in the face several times resulting in Resident #2 sustaining a right nasal bone fracture. On 2/24/25 at 11:00 AM, during an interview with Certified Nurse Assistant (CNA) # 1, she confirmed that Resident #1 had been wandering in resident rooms for months. Record review of the Progress Notes for Resident #1 revealed from 12/01/25-1/05/25 the 7:00 AM-7:00 PM nurses documented on five days	F 656	staff was conducted on March 5, 2025, on the facility care plan policy on implementation and updating of care plans All comprehensive care plans on residents identified to have new or ongoing behaviors such as but not limited to wandering and aggressive outburst shall be reviewed by the Director of Nursing and the MDS Coordinator weekly starting March 7, 2025, for four weeks then monthly for 3 months. The Director of Nursing shall bring the findings to the Quality Assurance Meeting on March 14, 2025 and monthly for 3 months.		

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F 656	Continued From page 3 that the resident wandered into other resident rooms constantly. ... During an interview with the Director of Nursing (DON) on 2/24/25 at 1:25 PM, she revealed after review of Resident #1's care plans that he did not have a care plan developed for the behavior of wandering. She revealed the purpose of the care plan is to direct the resident specific care needed. During an interview with the Administrator on 2/24/25 at 1:27 PM, the Administrator confirmed that Resident #1 should have had a care plan developed for the wandering behavior and confirmed failing to develop the care plan staff may not know how to take care of him. Record review of the "Admission Record" revealed Resident #1 was admitted by the facility on 10/10/24 with a diagnosis of Unspecified Dementia, Severe with Agitation.	F 656			
F 689 SS=G	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 staff and resident interview and record review the facility failed to provide adequate supervision to reduce the risk of an accident/hazards when a resident with behaviors	F 689	Resident #1 was placed on one-on-one monitoring on all shifts as of January 5,2025 and upon his return from Geri-Psych on January 20,2025 and	3/17/25	

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F 689	Continued From page 4 of wandering did not have any increased supervision/monitoring put in place resulting in the physical assault of a resident for one (1) of four (4) residents reviewed for accidents. (Resident #1) Findings include: Review of a document on facility letterhead provided by the Administrator revealed, "The facility does not have a policy that addresses resident supervision." Record review of the Facility Reported Incident revealed on 1/5/25 at approximately 8:00 - 8:30 PM, Resident #2 reported to Licensed Practical Nurse (LPN) #4 that Resident #1 "came in my room and was rumbling through my shirts and I told him to go on and he hit me in my face and then he did it about six more times." Resident #2 was unable to recall what time the incident occurred. On assessment by the Director of Nursing (DON) there was slight discoloration to inner corner of right eye and minimal swelling to right side of face around resident 's right eye. Computed Tomography (CT) of head and CT of Maxillo-facial were obtained on 1/6/25 revealing a nondepressed right nasal bone fracture. Resident #1, the aggressor in the situation had 1:1 sitter at bedside from 7 PM-7 AM for monitoring, scheduled daily. This was added after incident of wandering in the evening hours. Resident #1 was care planned for cursing staff, refusing care, attempting to hit staff and chasing staff. Resident #1 has an active diagnosis of severe dementia with behavioral disturbances. Resident #1 's cognition is severely impaired, her has poor decision making, and cannot recall events or retain safety information. There had been no	F 689	continues at this time. All residents have the potential to be affected A 100% audit of all residents by the Director of Nursing was conducted on February 24, 2025, to assess the need for increased staff monitoring or supervision. No other residents were found to require an increase in monitoring/supervision. An Inservice was conducted on February 28, 2025, by the Staff Education Nurse for all nursing staff regarding reporting resident incidents and behaviors such as wandering and aggression towards other residents/staff immediately for increased staff supervision and monitoring. All residents will be reviewed daily for the need of increased staff supervision by the Director of Nursing or Registered Nurse Supervisor for four weeks beginning on February 24, 2025, then weekly for eight weeks. The Director of Nursing shall bring audit findings to the Quality Assurance Meeting on March 14,2025 and monthly for three months.		

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F 689	Continued From page 5 previous incident of agitation with or aggression toward other residents. Resident #1 was transported to a behavioral health inpatient facility on 1/6/25. During an interview with the DON on 2/24/25 at 10:20 AM regarding a facility reported incident related to Resident #1 and Resident #2, she stated it was determined through staff and resident interviews, and investigation that Resident #1 wandered into Resident # 2's room on 1/5/25 and hit Resident #2 in the face several times resulting in Resident #2 sustaining a right nasal bone fracture. Record review of a Progress Note for Resident #1 documented by the DON revealed, late entry for 1/5/25: resident noted to have increased agitation, wandering, pacing and rummaging. It was reported by several residents that Resident #1 was in their room on 1/5/25. (Resident #3) reported that Resident #1 was in her room, raised his hand at her and yelled at her. It is noted that Resident #1 went into (Resident #2's room) and afterwards it was reported that (Resident #2) had slight discoloration and swelling to the right inner eye and eyebrow. (Resident #2) stated that the resident hit him in the face. During an interview with Resident # 2 on 2/24/25 at 10:30 AM, he confirmed that he remembered Resident #1 coming into his room and hitting him. He stated, "It was right after supertime; he started going through my clothes, and I kept telling him to go on, and then he hit me about six (6) times in the face. He had come into my room many times before but would leave when told this is not your room. "	F 689			

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F 689	Continued From page 6 Record review of a CT of the face for Resident #2 related to facial swelling dated 1/6/25 revealed a right nasal bone fracture. During an interview with Resident # 3 on 2/24/25 at 10:45 AM she stated that on 1/5/25 around 5:15 PM to 5:30 PM, Resident #1 came in her room. She stated, "I kept telling him it was not his room. He raised his hand and acted like he was going to hit me and then walked out of the room." She confirmed she immediately found the nurse on duty and reported what happened. When asked how she knew who the resident was, she stated because "this was not the first time he had been in my room and the staff told me his name." During an interview on 2/24/25 at 11:00 AM, with Certified Nurse Assistant (CNA) # 1, she confirmed that Resident #1 had been wandering in resident rooms for months. During an interview with CNA #2 on 2/24/25 at 11:50 AM, she confirmed that Resident #1 had been wandering into other resident's rooms for a good while and had to often be redirected to come out of the other resident's rooms. She stated he does have a wander guard but stated that it does not alert staff of him entering other resident rooms. She confirmed she had reported wandering into other rooms numerous times, and confirmed she was unaware of any special monitoring for Resident #1 during the day. During an interview with Licensed Practical Nurse (LPN) #1 on 2/24/25 at 12:00 PM, she stated she works the 7:00 AM-7:00 PM shift and confirmed she was aware that Resident #1 was wandering in and out of other resident rooms all during the day. She revealed the wandering was	F 689			

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F 689	Continued From page 7 documented in the resident's Progress Notes and confirmed that the Administration staff was made aware, and they placed him with one-on-one sitters from 7:00 PM-7:00 AM back in November 2024. She also revealed it was difficult to watch Resident #1 and confirmed she felt he needed to have been one-on-one supervision during the day as well. During an interview with CNA #3 on 2/24/25 at 1:20 PM, she confirmed that Resident #1 continuously roamed into other resident's rooms during the day before the incident on 1/5/25. She stated he was not easily redirected and confirmed she had reported the behavior. During an interview with the DON on 2/24/25 at 1:25 PM, she revealed after review of the Progress Notes for Resident #1 she confirmed that he had been wandering into other resident rooms during the 7:00 AM-7:00 PM shift during the month of December. She then stated that previously she thought the behavior was only occurring at night and had put the resident on 1:1 supervision on the 7 PM-7 AM shift. She confirmed that the documented wandering into other resident rooms during the day should have already been identified and preventative measures put in place to potentially prevent an incident from occurring. The DON then revealed failing to put interventions in place to increase supervision could lead to the resident or someone else being hurt. During an interview with the Administrator on 2/24/25 at 1:27 PM, she confirmed that the behavior of wandering in other resident's rooms during the day hours should have been identified and interventions put in place.	F 689			

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F 689	Continued From page 8 During an interview with LPN #2 on 2/24/25 at 1:40 PM, she revealed she works 7:00 AM-7:00 PM shift and confirmed Resident #1 was wandering all day and would go in and out of rooms before the incident. She also confirmed she was unaware of any special increased monitoring before the incident in January 2025 on the 7:00 AM-7:00 PM shift. During an interview with LPN #3 on 2/24/25 at 3:20 PM she revealed she worked from 7:00 AM-7:00 PM on the day of the incident 1/5/25. She confirmed that Resident #1 had been constantly wandering in other resident's rooms. She confirmed that she was unaware of any special monitoring of the resident at that time to prevent accidents related to him continually going into other rooms. She also confirmed this behavior had been reported numerous times and documented. During an interview with LPN #4 on 2/24/25 at 3:50 PM, she revealed she worked the night of 1/5/25 7:00 PM-7:00 AM. She revealed Resident #2 reported to her at approximately 8:00 PM-8:30 PM that the "old man" came into his room rumbling through his stuff and hit him several times in the face. Record review of the Progress Notes for Resident #1 revealed from 12/01/25-1/05/25 the 7:00 AM-7:00 PM nurses documented on five (5) days that the resident wandered into other resident rooms constantly. Record review of the "Admission Record" revealed Resident #1 was admitted by the facility on 10/10/24 with a diagnosis of Unspecified	F 689			

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F 689	Continued From page 9 Dementia, Severe with Agitation. Record review of Resident #1's Section C of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/18/24 revealed a Brief Interview for Mental Status (BIMS) score was 4, indicating the resident was severely cognitively impaired. Section E0900: Wandering presence and frequency: coded 3.) Behavior of this type occurs daily. Record review of the "Admission Record" revealed Resident #2 was admitted by the facility on 7/3/24 with a diagnoses that included Protein Calorie Malnutrition, Muscle Weakness and Right Heart Failure. Record review of Resident #2's Section C of the Quarterly MDS with an ARD of 1/7/25 revealed a BIMS score was 5, indicating the resident was severely cognitively impaired. Review of a Quarterly Review progress note for Resident #2 dated 1/6/25 revealed "He is able to make his needs known and decisions for self daily." Record review of the "Admission Record" revealed Resident #3 was admitted by the facility on 1/25/24 with a diagnosis that included a Stress Fracture of the Right Ankle. Record review of Resident #3's Section C of the Annual MDS with an ARD of 1/24/25 revealed a BIMS score was 15, indicating the resident was cognitively intact.	F 689			