STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YALOBUSHA COUNTY NURSING HOME	630 SOUTH MAIN STREET , WATER VALLEY, Mississippi, 38965

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F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and a complaint investigation (CI) MS #2631817 at the facility from 10/06/25 through 10/09/25. During the survey, the SA determined the facility was not in compliance with requirements for participation in Medicare and Medicaid and cited regulatory deficiencies at F641, F657, F761, and F812. There were no deficiencies cited related to the CI. The census at the time of the survey was 104 and the facility was licensed for 122 beds.	F0000		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or	F0641		

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

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F0641 SS = D	Continued from page 1 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and facility policy review, the facility failed to accurately complete the Minimum Data Set (MDS) assessment for four (4) of 26 MDS assessments reviewed. Resident #10, #15, #16, and #92 Findings Include: Review of the facility policy titled “MDS Assessment Accuracy and Correction” undated, revealed, “The facility shall submit a correct MDS assessment as required by scheduling requirements. The MDS shall be completed and verified by the Registered Nurse and to be accurate to the best of that nurse’s knowledge...” Resident #10 Record review of the "Bowel and Bladder Program Screening" dated 8/11/25, revealed Resident #10 always voids without incontinence, she never was incontinent of stool and that she was independent with toileting. Record review of the Admission MDS assessment with an Assessment Reference Date (ARD) of 8/12/2025 revealed, under Section H - Bladder and Bowel, revealed Resident #10 was frequently incontinent of bladder and was occasionally incontinent of bowel. Section C revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had severe cognitive impairment. During an interview on 10/07/2025 at 3:05 PM, with the Administrator (ADM), confirmed Resident #10's Bowel and Bladder Assessment dated 8/11/25 and the MDS assessment with an ARD date of 8/12/25 "do not tell the same story." During an interview on 10/8/2025 at 9:15 AM, with the MDS Nurse, she confirmed the MDS assessment with an ARD of 8/12/25 was not coded correctly. She stated, "I don't know what happened, but the information that was entered was incorrect."	F0641		

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F0641 SS = D	Continued from page 2 Record review of the “Admission Record” revealed the facility admitted Resident #10 on 7/30/25 with medical diagnoses that included chronic kidney disease, stage 3B and dysuria. Resident #15 An observation on 10/06/2025 at 10:49 AM, revealed Resident #15 ambulating in the hall with a wander guard bracelet intact to her left ankle. Record review of Resident #15's MDS with an ARD of 08/21/25 under Section P - Restraints and Alarms, revealed that Wander/Elopement alarm was not used. Record review of Resident #15's "Medication Review Report" revealed a physician's order dated 07/30/25 for wander guard intact at all times and to check functioning every shift. During an interview on 10/08/25 at 9:30 AM, the MDS Nurse, confirmed that Resident #15's MDS under Section P - Restraints and Alarms, was answered incorrectly, because she had marked that the Wander/Elopement alarm was not used. She admitted that she was aware that Resident #15 wore a wander guard and should have marked that it was used daily. She stated, "I just missed it,” and revealed that the MDS Assessments should be accurate to reflect correctly in the care plan. Record review of Resident #15's "Admission Record" revealed the facility admitted the resident on 11/21/23 with diagnoses that included Schizophrenia and Unspecified Dementia, Mild, with Anxiety. Record review of Resident #15's MDS with an ARD of 08/21/25 revealed under Section C, a BIMS Score of 08 which indicated that the resident had moderate cognitive deficits. Resident #16 Record review of Resident #16’s Preadmission Screening and Resident Review (PASRR) dated 7/17/29 revealed, “The individual meets criteria for having a diagnosis of mental illness as defined by PASRR” with Axis I primary diagnosis of schizoaffective disorder. Record review of the Annual MDS with an ARD 2/18/25 revealed under section A1500, “Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?” No, was indicated.	F0641		

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F0641 SS = D	Continued from page 3 An interview with the Director of Nursing (DON) on 10/8/25 at 9:06 AM, revealed her expectations were for the MDS assessment to be completed accurately. An interview and record review with the MDS Nurse on 10/08/25 at 9:48 AM confirmed after reviewing the record that she did not complete Resident #16's assessment accurately and stated, "I guess I just got in a hurry and missed it." Record review of the "Admission Record" revealed the facility admitted Resident #16 on 4/11/17 with medical diagnoses that included Paraplegia. Record review of the MDS with an ARD of 8/19/25 revealed under section C a BIMS summary score of 12, indicating Resident #16 was moderately cognitively impaired. Resident #92 An observation on 10/07/2025 at 8:54 AM revealed Resident #92 sitting in a high-back wheelchair with a motion sensor alarm in the seat of her chair. Record review of Resident #92's "Medication Review Report" revealed a physician order dated 11/27/24 for a pressure sensitive alarm to be intact at all times in wheelchair and bed to alert staff of attempts to transfer self-unattended. Record review of Resident #92's MDS with ARD of 07/16/25 under Section P - Restraints and Alarms, revealed that a motion sensor alarm was not used. During an interview on 10/08/25 at 9:20 AM, the MDS Nurse, confirmed that Resident #92's MDS Section P - Restraints and Alarms, was coded inaccurately. She revealed that the motion sensor alarm should have been marked as used. The MDS nurse revealed that she knew that Resident #92 used an alarm and confirmed that she marked it wrong by mistake. She also stated that it "gets to be too much sometimes" and revealed that she needed to be more thorough, and slow down to ensure the accuracy of the assessments. Record review of Resident #92's "Admission Record" revealed the facility admitted the resident on 07/12/24 with diagnoses that included Parkinson's Disease, Repeated Falls, Restlessness, and Agitation. Record review of Resident #92's MDS with an ARD of 07/16/25 revealed under Section C, a BIMS Score of 05	F0641		

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F0641 SS = D	Continued from page 4 which indicated that she had severe cognitive deficits.	F0641		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure residents were invited and given the opportunity to participate in their Care Plan meetings for three (3) of five (5) residents reviewed for care planning. Resident #3, Resident #9, and Resident #38. Findings Include: Review of the undated facility policy titled "Care Plan Meeting" revealed, "The MDS (Minimum Data Set) Coordinator shall notify the resident/resident	F0657		

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F0657 SS = D	Continued from page 5 representative in writing or telephone of the upcoming care plan conference" and "The MDS coordinator shall make arrangements for each resident/representative to actively attend a care plan conference with IDT (Interdisciplinary Team) members if the resident/representative desires during a time that accommodates the resident/representative...." Resident #3 Record review of "Care Plan Report" for care conference review dated 8/4/25, revealed no signatures noted for resident or family indicating participation in care conference review. During an interview on 10/06/2025 at 10:26 AM, with Resident #3, she revealed that she had never been invited to a care plan meeting. She admitted that she had no idea what a care plan meeting was about. Record review of the "Admission Record" indicated that the facility admitted Resident #3 on 5/16/2022 with medical diagnoses that included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/28/25 revealed under section C, a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #3 was cognitively intact. Resident #9 During an interview on 10/06/2025 at 10:22 AM, with Resident #9, she revealed that she was not aware of any care plan meetings. She verbalized, "I don't know what kind of meetings you are talking about." Record review of "Care Plan Report" for care conference review dated 9/29/25, revealed no signatures noted for the resident or family indicating participation in the care conference review. Record review of the "Admission Record" indicated that the facility admitted Resident #9 on 3/3/2025 with medical diagnoses that included Parkinson's Disease without Dyskinesia, with Fluctuations. Record review of the MDS with an ARD of 9/19/25 revealed under section C, a BIMS summary score of 14 which indicated Resident #9 was cognitively intact. Resident #38	F0657		

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F0657 SS = D	Continued from page 6 During an interview on 10/07/2025 at 8:40 AM with Resident #38, she confirmed that she was not invited to any care plan meetings and didn't know what a care plan was. Resident #38 revealed that she would like to attend the meetings and be involved with her care if she could. Record review of Resident #38's "Care Plan Report" for care conference review dated 07/06/25, revealed no signatures for resident or family indicating participation in the care plan meeting and no documentation of resident invitation to attend the meeting. An interview on 10/07/25 at 3:52 PM, the MDS Nurse confirmed that she had assumed Resident #3, Resident #9, and Resident #38 knew what a care plan was, but admitted that she had not invited them to any care plan meetings. The MDS Nurse stated, "It's my fault" and "I'll fix it." She also confirmed that these residents should be given the opportunity to attend and participate in care plan meetings. She admitted that she was responsible for sending out invitations to residents and family for their care plan meetings. An interview on 10/08/25 at 8:50 AM, with the Director of Nursing (DON), confirmed that the MDS Nurse was supposed to send out letters to invite the resident and family members to the care plan meetings and admitted that there was no documentation showing that Residents #3, #9 and #38 were invited. The DON revealed that it was important to invite residents and family to the care plan meetings in order to allow them the opportunity to participate in their care. Record review of Resident #38's "Admission Record" revealed the facility admitted the resident on 09/27/24 with medical diagnoses that included end stage renal disease and major depressive disorder. Record review of Resident #38's MDS with an ARD of 09/30/25 revealed under Section C a BIMS Score of 15 which indicated she was cognitively intact.	F0657		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate	F0761		

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F0761 SS = D	Continued from page 7 accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff interviews, and facility policy review, the facility failed to ensure that drugs and biologicals were stored in a secure manner to prevent unauthorized access for two (2) of four (4) days of survey. Findings include: Review of the facility policy titled, "Medication Cart Security/Medication Room Security" undated, revealed, "The nurse shall ensure the medication care always remains secured to prevent unauthorized entry. The medication cart shall be locked when not in use or within the nurse's reach..." An observation and interview on 10/7/2025 at 11:37 AM, revealed an unattended medication cart in the South Hall with the drawers unlocked and no staff present in the immediate area. An interview with Licensed Practical Nurse (LPN) #1 confirmed the cart should never be left unlocked and unattended because a resident could get into it. An observation and interview on 10/08/2025 at 11:20 AM, revealed an unattended medication cart at the D wing nurses station with the drawers unlocked and no staff present in the immediate area. An interview with LPN #2 confirmed that the cart should never be left unlocked and unattended because a resident could get into the	F0761		

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F0761 SS = D	Continued from page 8 cart and possibly take a medication that was not ordered for them. During an interview on 10/8/2025 at 11:41 AM, the Director of Nursing (DON), confirmed that nurses should never leave a medication cart unattended and unlocked. She stated this could cause medication errors and could be detrimental to a resident.	F0761		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews and facility policy review, the facility failed to ensure the residents' food was stored, thawed and monitored under sanitary conditions for two (2) of four (4) kitchen tours. Findings Include Review of the facility policy titled," Refrigerator/Freezer Temperature Checks" with no revision date, revealed, "The kitchen supervisor and/or the Dietary Manager shall check all refrigerator temperatures and freezer temperatures at least twice daily..."	F0812		

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F0812 SS = F	Continued from page 9 Review of the facility policy titled, "Food Preparation and Service' with no revision date, revealed, "…Thawing Frozen Food 1. Foods will not be thawed at room temperature. Thawing procedures include… a. thawing in the refrigerator…b. completely submerging in cold running water…c. thawing in the microwave, then cooking and serving immediately…d. thawing as part of a continuous cooking process…". An observation on 10/06/2025 at 10:30 AM, during the initial kitchen tour revealed there was no refrigerator temperature log for the month of October and approximately 200 raw chicken drumsticks were sitting directly in the kitchen sink. The chicken appeared to be partially thawed on the top layer with no container, ice, or cold running water observed under or around the chicken. In an interview on 10/06/25 at 10:35 AM, the Dietary Manager (DM) stated, "It's the first of the month and I haven't had time to get the temperature log up. She then stated," We're about to cook it." in reference to the partially frozen chicken drumsticks in the sink. The DM did not provide documentation or describe a safe thawing method. She confirmed there was no container for the chicken and no running water and stated, " Food not properly thawed and stored can cause food-borne illnesses." A second kitchen tour on 10/07/25 at 9:00 AM, revealed a refrigerator temperature log was posted. The DM provided a temperature log for October with no temperature logged for 10/01/25-10/05/25. The first temperature logged was on 10/06/25. When asked about the importance of checking temperatures on refrigerators, she stated, "to ensure proper food storage for the safety of the residents." On 10/07/25 at 2:00 PM, an interview with the Director of Nursing (DON) confirmed that the improper storage of chicken could cause a food borne illness and that refrigerator temperatures should have been checked on the refrigerator and should have been posted and visible in the kitchen.	F0812		