MSDH - Health Facilities Licensure and Certification

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 67RH | A. BUILDING: _____ B. WING _____ | C 09/14/2023 |

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| RULEVILLE NURSING AND REHABILITATION CENTEI | 800 STANSEL DR RULEVILLE, MS 38771 |

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| M 000 | Initial Comments<br><br>The State Agency (SA) conducted a complaint survey (MS CI # 22653) at the facility on 9/14/23. During the survey, the SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm. The SA identified non-compliance and cited M500 for CI # 22653. There<br>The census at the time of the survey was 111 and the facility is licensed for 111 beds. | M 000 | | |
| M 500 | 45.17.2 Residents' Rights<br><br>Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility:<br><br>1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents;<br><br>2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;<br><br>3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his | M 500 | | 10/20/23 |

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| M 500 | Continued From page 1<br>medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;<br><br>4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;<br><br>5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;<br><br>6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the | M 500 | | |

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| M 500 | Continued From page 2 | M 500 | | |

facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail

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| M 500 | Continued From page 3<br>unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and<br><br>16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights.<br><br>This Statute is not met as evidenced by:<br>Level II<br><br>Based on record review, staff and resident interview and facility policy review the facility failed to ensure a resident was free from abuse when a Certified Nursing Assistant (CNA) threw | M 500 | Resident #1 was assessed by the Director of Nursing (DNS) on 08/24/2023 with no adverse findings noted. On 08/24/2023, Resident #1's Representative (Resident is own Representative) and Medical Director were both notified of the incident that | |

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| M 500 | Continued From page 4<br>water on a resident for one (1) of six (6) residents reviewed for abuse. Resident # 1.<br><br>Findings include:<br><br>A record review of the facility policy titled, "Abuse Prevention", with a revision date of 10/22, revealed "Policy: The facility is committed to protecting the residents from abuse by anyone including but not necessarily limited to: facility staff...or any other individual ..."<br><br>A record review of the facility "Supervisor Investigation Summary Report Form" revealed that on August 24, 2023, the Director of Nursing (DON) reported to the Administrator that Registered Nurse (RN) #1 had reported to her an employee-to-resident abuse altercation between Resident # 1 and CNA #1. RN #1 noticed Resident #1's shirt was wet and noticed water on the floor. Resident #1 stated that CNA #1 poured a cup of ice-cold water on her due to CNA #1 stating her foot was purposely run over by Resident #1. CNA # 1 was observed by CNA # 2 pouring water on Resident # 1's back after Resident #1 rolled over CNA #1's foot with her wheelchair. Licensed Practical Nurse (LPN) # 1 heard Resident # 1 yelling in the hall and went to check on her. When she asked what happened Resident #1 stated that CNA #1 poured cold water on her. LPN # 1 noticed that Resident # 1's shirt, hair and pants were wet. CNA #1 was removed from the resident area. Upon interview by the Administrator and DON, CNA #1 stated that she did not pour water on the resident and she was only playing and threw her damp hands from the sink to the resident's body. CNA #1 was suspended pending further investigation and subsequently turned in her resignation effective 8/25/23. The facility investigation revealed that | M 500 | involved Certified Nursing Assistant #1 pouring a cold cup of ice water on Resident #1. Medical Director was notified on 08/24/2023 of incident with no change of orders noted. Certified Nursing Assistant #1 last scheduled workday was 08/24/2023. On 08/24/2023, Certified Nursing Assistant #1 was placed on immediate suspension and resigned on 08/25/2023.<br><br>All residents were identified on 08/24/2023 as having the potential to be affected by this stated deficiency.<br><br>In-services were held on all staff members on 08/24/2023 and 09/21/2023 by the Administrator on "Resident Bill of Rights" and "Abuse Prevention," to include treating all residents with respect and ensuring residents are free from mental and physical abuse. Starting on 08/24/2023, Social Services initiated weekly meetings with cognitive residents weekly times twelve (12) weeks to include treating all residents with respect and ensuring residents are free from mental and physical abuse. Starting on 08/24/2023, the DNS initiated weekly head to toe assessments of non-cognitive residents weekly times twelve (12) weeks to include the treatment of all residents with respects and ensuring residents are free from mental and physical abuse.<br><br>Starting on 09/25/2023, the Assistant Director of Nursing (ADNS) initiated two (2) times a week times eight (8) weeks, then weekly times four (4) weeks staff interview audits, to ensure staff knowledge | |

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| M 500 | Continued From page 5<br><br>CNA #1 poured water on Resident # 1. The facility reported this incident to the local Police Department, Survey Agency (SA), Attorney General (AG) office, the State Ombudsman office.<br><br>During an interview on 9/14/23 at 10:15 AM, with Resident #1 she revealed that on 8/24/23, after lunch she was rolling up the hall in her wheelchair and CNA #1 said to her that she ran over her foot. CNA #1 then threw a cup of cold water on her left shoulder and ran into another resident's room smiling. She stated a floor nurse came and checked on her to make sure she was alright and took her to the front to report the incident.<br><br>During an interview on 9/14/23 at 12:34 PM, with LPN #1, she stated on 8/24/23 the CNAs were picking up trays in the hall and she saw Resident #1 coming up the hall in her wheelchair. She stated that she told Resident #1 that she was getting her medications ready for her to take. LPN #1 stated Resident #1 continued up the hall toward the nurses' station. She stated she had heard Resident #1 yelling, so she came out from behind the nurses' station and saw that the back and front of Resident #1's shirt was wet, her hair was wet and there was water in the floor. She then asked who got her wet and Resident #1 stated that CNA #1 had thrown water on her. She stated Resident #1 took her medications and then rolled toward the front lobby and she reported the incident to RN #1.<br><br>During an interview on 9/14/23 at 12:42 PM, with CNA #2 she stated on the day of the incident she was helping pick up lunch trays and was bringing them to the cart on the hall. She stated she saw Resident # 1 run over CNA #1's foot and then CNA #1 poured a cup of water on Resident # 1. | M 500 | of resident abuse and neglect to include the treatment of all residents with respect and ensuring residents are free from meal and physical abuse. The ADNS immediately addressed any negative findings, including notification of the Administrator. Results of the weekly audits are presented by the Administrator to the Quality Assurance Committee monthly times three (3) months starting with the Quality Assurance meeting on 09/27/2023. The next Quality Assurance Committee meeting will be held on 10/18/2023. The Quality Assurance Committee will determine further monitoring and/or action needed. | |

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| M 500 | Continued From page 6<br><br>During a telephone interview on 9/14/23 at 1:41 PM, with CNA #1 she stated that she was picking up lunch trays and Resident # 1 rolled over her foot with the wheelchair. When asked what she did when the resident ran over her foot, she stated that she said, "Resident #1 (proper name) you rolled over my foot." CNA #1 stated right after this another resident called her into the room to put on his house shoes on. She stated that she washed her hands after she had cared for the other resident and there were no paper towels in the bathroom so when she came out of the room, she shook her wet hands at Resident #1, just playing with her. She verified that she did turn in her notice the next day, stating it was because she had previous issues with her schedule.<br><br>During an interview with the Administrator and DON on 9/14/23 at 2:20 PM, they verified they received a report that Resident #1 stated that CNA #1 threw water on her. They stated that Resident # 1 was brought to the Administrator's office, and she reported that CNA #1 threw water on her in retaliation for rolling over her foot with the wheelchair. They verified that the residents clothing was wet at that time. They both verified that based on their investigation CNA #1 threw water on Resident #1.<br><br>Record review of the facility Face Sheet for Resident # 1 revealed that she was admitted to the facility on 3/8/22, with diagnoses that include Schizophrenia, Bipolar Disorder, Pain, and Anxiety.<br><br>Record review of Resident #1's Quarterly Minimum Data Set Assessment (MDS), with an Assessment Reference Date (ARD) of 8/14/23, revealed a Brief Interview for Mental Status | M 500 | | |

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| M 500 | Continued From page 7<br>(BIMS) score of 15, indicating that the resident is cognitively intact. | M 500 | | |