STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. BUILDING _____ B. WING _____	C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RULEVILLE NURSING AND REHABILITATION CENTER LLC	800 STANSEL DR RULEVILLE, MS 38771

(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 a Complaint Investigation (CI MS#22653) at the facility on 9/14/23. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services. The SA identified non-compliance and cited F600 for CI MS# 22653 for failure to prevent abuse. The census at the time of the survey was 111 with a bed capacity of 111 bed.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: 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 water on a resident for one (1) of six (6) residents reviewed for abuse. Resident # 1.	F 600	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	10/20/23

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

Electronically Signed | 10/05/2023

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F 600	Continued From page 1 Findings include: 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 ..." 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 CNA #1 poured water on Resident # 1. The	F 600	incident that 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. All residents were identified on 08/24/2023 as having the potential to be affected by this stated deficiency. 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. 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	

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F 600	Continued From page 2 facility reported this incident to the local Police Department, Survey Agency (SA), Attorney General (AG) office, the State Ombudsman office. 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. 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. 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.	F 600	interview audits, to ensure staff knowledge 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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F 600	Continued From page 3	F 600		

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.

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.

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.

Record review of Resident #1's Quarterly Minimum Data Set Assessment (MDS), with an Assessment Reference Date (ARD) of 8/14/23,

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F 600	Continued From page 4 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating that the resident is cognitively intact.	F 600		