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 06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RULEVILLE NURSING AND REHABILITATION CENTEI	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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a complaint investigation (CI MS# 25499), at the facility on 6/25/24. During the survey, the SA determined that the facility was not in compliance with the requirements of the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The SA identified non-compliance and cited M 500 for failure to protect resident's rights to be free from restraints for CI MS# 25499. The census at the time of the survey was 107 with a bed capacity of 111 beds.	M 000		
M 500 SS=D	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 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; 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; 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	M 500		7/20/24

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M 500	Continued From page 1	M 500		

contraindicated (as documented by a physician or nurse practitioner/physician assistant in his 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;

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;

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;

6. may manage his personal financial affairs, or is

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M 500	Continued From page 2	M 500		

given at least a quarterly accounting of financial transactions made on his behalf should the 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

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M 500	Continued From page 3 facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 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); 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); 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 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. This Statute is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review the facility failed to prevent a resident from being physically restrained with a sheet tied to the wheelchair. The	M 500	On 6/25/24 a head to toe body audit was conducted by the Director of Nursing (DNS) on Resident #1 regarding the use of being physically restrained with a sheet	

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M 500	Continued From page 4 facility also failed to obtain physician orders, consent and failed to assess a resident for the need of restraints (mattress with elevated sides and wedges) for one (1) of six (6) residents reviewed. Resident #1. Findings included: Review of the facility policy titled, "Restraint Evaluation & (and) Restraint Reduction," revised 12/23, revealed, "Policy: as per OBRA (Omnibus Budget Reconciliation Act) requirements, all residents have the right to be unrestrained. Restraints should be used only as a last alternative and only when other less restrictive measures have been tried and rejected." ...Definition: "Physical Restraints" are defined as any manual method of physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access. ...Procedure: 2.) All residents using a restraint are to be evaluated utilizing the Restraint Evaluation Form. ...4.) A specific physician's order is to be entered in the resident's medical record which details the medical reason, type of restraint and when to be used..." Record review of the facility "occurrence", completed by the Director of Nursing (DON) revealed that an investigation was conducted on 6/10/24, when the DON was informed of a resident possibly having a sheet tied on her wheelchair the previous day. After staff interview which revealed four (4) CNAs stated they saw the resident restrained on 6/9/24 with a sheet tied around the wheelchair, the facility determined that because the resident was recently combative and sliding down in the chair; someone may have tied	M 500	tied to the wheelchair and the failure to obtain a physician order, consent and assess a resident for the need of restraints (mattress with elevated sides and wedges). There were no negative effects found by the DNS. All residents could be affected by this deficient practice. An in-service was initiated on 6/25/24 by Staff Development Coordinator to all nursing staff including nurses including registered nurses, licensed practical nurses, and certified nursing assistants regarding restraint use, restraint evaluation, obtaining a physician order, restraint consent, and assessing a residents for the need of a restraint. An audit was initiated by the Unit Managers on 6/25/24 of 100% of residents restraint evaluation use. Any negative findings will be address to ensure that each resident in a physical restraint has a physician order, restraint consent, and an assessed need for the restraint. Stating on 6/26/24 the DNS initiated monitoring 10 residents five (5) times week times six (6) weeks, then five (5) residents three (3) times a week times six (6) weeks to ensure that residents with new restraint use has a restraint evaluation, a physician order, a restraint consent, and an assessment need for a restraint. Any concerns will be immediately addressed. The results of the	

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M 500	Continued From page 5 a sheet loosely around her wheelchair. An observation and interview on 6/25/24 at 8:30 AM, with Certified Nursing Assistant (CNA) #1 revealed Resident #1 was in bed on a mattress with elevated sides that extended the length of the mattress and four (4) - 18 by eight (8) inch foam wedges which were present on either side of her upper and lower body. CNA #1 verified that Resident #1 currently had a mattress with elevated sides and wedges in use in the bed to keep her off of the floor. She stated that the "daily care guide" lets her know what type of devices the resident should have. An interview with Licensed Practical Nurse (LPN) #1 on 6/25/24 at 8:40 AM, stated that Resident #1 had a history of falls and that the mattress with elevated sides and wedges were to keep the resident from falling. She stated that she has to check the resident about every 30 minutes because she gets up unassisted. A record review of the facilities "Daily Care Guide" for Resident #1 revealed, under interventions "Concave bed with elevated sides ..." There were no interventions listed for the use of foam wedges. A record review of the "Physician's Order List" for Resident #1 revealed no physician's orders for a mattress with elevated sides or wedges. Record review of a written statement on company letter head, provided by the Administrator, undated, revealed that the facility did not have physician's orders, consents or assessments for the mattress and wedges that were in place for Resident #1.	M 500	audits/monitoring will be forwarded to the monthly Quality Assurance Committee times three (3) months beginning July 15, 2024. The Quality Assurance Committee will recommend the frequency of audits/monitor based upon the results achieved.	

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M 500	Continued From page 6 In a telephone interview with CNA #3 on 6/25/24 at 9:00 AM, she stated when she came on duty a little after 7:00 AM on 6/9/24, she noticed Resident #1 had a sheet tied around her waist tied in a knot behind the wheelchair. She stated that she knew that the resident should not be restrained that way. CNA #3 stated that she brought it to the attention of the resident's nurse LPN #1. CNA #3 stated LPN #1 told her that it was to aid in the resident's safety and for her protection. During an interview with CNA #1 on 6/25/24 at 9:35 AM, she stated that on 6/9/24 after lunch, she saw Resident #1 tied in the wheelchair with a sheet. She stated that CNA #2 told her the nurse put it on. CNA #1 stated she and CNA #2 removed the sheet and showered the resident but did not reapply the sheet. In a telephone interview 6/25/24 at 10:40 AM, with CNA #2 she stated on 6/9/24 at 9:30 AM, while making rounds she saw Resident #1 sitting in the day room restrained in the wheelchair with a sheet with a knot tied in the back. She stated she untied the sheet to take the resident to her room to provide incontinent care. CNA #2 states that she left the sheet off of the resident but when she went to get Resident #1 after lunch, she was restrained with a sheet in the wheelchair again. She stated that one of her co-workers informed her that the nurse said it was for the resident's safety and not to remove it. CNA #2 stated that she and CNA #1 removed the sheet and showered the resident. She stated that they did not reapply the sheet. In an interview with LPN #1 on 6/25/24 at 10:45 AM, she verified that she was assigned to Resident #1 on 6/9/24. LPN #1 denied any	M 500		

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M 500	Continued From page 7	M 500		

knowledge of Resident #1 being restrained in the wheelchair with a sheet. She stated she did not see the resident restrained and she denied anyone bringing to her attention that the resident was restrained. LPN #1 denied restraining the resident or telling staff that it was for the resident's safety and protection.

During an interview with the DON on 6/25/24 at 11:00 AM, she verified that based on her investigation it was likely that someone restrained Resident #1 in the wheelchair with a sheet on 6/9/24, because the resident had recently been combative and had slid down in the wheelchair. She stated that she was unable to determine who had restrained the resident. The DON stated that she felt that they had done it for the resident's safety and did not feel that the resident was at risk of any injuries related to being restrained in the wheelchair with a sheet. During further interview the DON verified that there were no wedges listed as interventions on Resident #1's "Daily Care Guide" and agreed that there were no physician's orders for the use of a mattress with elevated sides or wedges for Resident #1.

During an interview with the Unit Manager (UM) on 6/25/24 at 1:16 PM, she revealed that a resident should never have any restraints applied without assessment , physicians' orders, and family consent. She stated restraining a resident places the resident at risk of sliding in the chair and getting choked.

Record review of the "Face Sheet" revealed the facility admitted Resident #1 on 5/6/2024, with diagnoses that include Dementia and Impulse Disorder.

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M 500	Continued From page 8	M 500		

Level II

Based on observation, staff interview, record review, and facility policy review the facility failed to prevent a resident from being physically restrained with a sheet tied to the wheelchair. The facility also failed to obtain physician orders, consent and failed to assess a resident for the need of restraints (mattress with elevated sides and wedges) for one (1) of six (6) residents reviewed. Resident #1.

Findings include:

Review of the facility policy titled, "Restraint Evaluation & (and) Restraint Reduction," revised 12/23, revealed, "Policy: as per OBRA (Omnibus Budget Reconciliation Act) requirements, all residents have the right to be unrestrained. Restraints should be used only as a last alternative and only when other less restrictive measures have been tried and rejected." ...Definition: "Physical Restraints" are defined as any manual method of physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access. ...Procedure: 2.) All

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M 500	Continued From page 9	M 500		

residents using a restraint are to be evaluated utilizing the Restraint Evaluation Form. ...4.) A specific physician's order is to be entered in the resident's medical record which details the medical reason, type of restraint and when to be used..."

Record review of the facility "occurrence", completed by the Director of Nursing (DON) revealed that an investigation was conducted on 6/10/24, when the DON was informed of a resident possibly having a sheet tied on her wheelchair the previous day. After staff interview which revealed four (4) CNAs stated they saw the resident restrained on 6/9/24 with a sheet tied around the wheelchair, the facility determined that because the resident was recently combative and sliding down in the chair; someone may have tied a sheet loosely around her wheelchair.

An observation and interview on 6/25/24 at 8:30 AM, with Certified Nursing Assistant (CNA) #1 revealed Resident #1 was in bed on a mattress with elevated sides that extended the length of the mattress and four (4) - 18 by eight (8) inch foam wedges which were present on either side of her upper and lower body. CNA #1 verified that Resident #1 currently had a mattress with elevated sides and wedges in use in the bed to keep her off of the floor. She stated that the "daily care guide" lets her know what type of devices the resident should have.

An interview with Licensed Practical Nurse (LPN) #1 on 6/25/24 at 8:40 AM, stated that Resident #1 had a history of falls and that the mattress with elevated sides and wedges were to keep the resident from falling. She stated that she has to check the resident about every 30 minutes because she gets up unassisted.

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M 500	Continued From page 10 A record review of the facilities "Daily Care Guide" for Resident #1 revealed, under interventions "Concave bed with elevated sides ..." There were no interventions listed for the use of foam wedges. A record review of the "Physician's Order List" for Resident #1 revealed no physician's orders for a mattress with elevated sides or wedges. Record review of a written statement on company letter head, provided by the Administrator, undated, revealed that the facility did not have physician's orders, consents or assessments for the mattress and wedges that were in place for Resident #1. In a telephone interview with CNA #3 on 6/25/24 at 9:00 AM, she stated when she came on duty a little after 7:00 AM on 6/9/24, she noticed Resident #1 had a sheet tied around her waist tied in a knot behind the wheelchair. She stated that she knew that the resident should not be restrained that way. CNA #3 stated that she brought it to the attention of the resident's nurse LPN #1. CNA #3 stated LPN #1 told her that it was to aid in the resident's safety and for her protection. During an interview with CNA #1 on 6/25/24 at 9:35 AM, she stated that on 6/9/24 after lunch, she saw Resident #1 tied in the wheelchair with a sheet. She stated that CNA #2 told her the nurse put it on. CNA #1 stated she and CNA #2 removed the sheet and showered the resident but did not reapply the sheet. In a telephone interview 6/25/24 at 10:40 AM, with CNA #2 she stated on 6/9/24 at 9:30 AM,	M 500		

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M 500	Continued From page 11 while making rounds she saw Resident #1 sitting in the day room restrained in the wheelchair with a sheet with a knot tied in the back. She stated she untied the sheet to take the resident to her room to provide incontinent care. CNA #2 states that she left the sheet off of the resident but when she went to get Resident #1 after lunch, she was restrained with a sheet in the wheelchair again. She stated that one of her co-workers informed her that the nurse said it was for the resident's safety and not to remove it. CNA #2 stated that she and CNA #1 removed the sheet and showered the resident. She stated that they did not reapply the sheet. In an interview with LPN #1 on 6/25/24 at 10:45 AM, she verified that she was assigned to Resident #1 on 6/9/24. LPN #1 denied any knowledge of Resident #1 being restrained in the wheelchair with a sheet. She stated she did not see the resident restrained and she denied anyone bringing to her attention that the resident was restrained. LPN #1 denied restraining the resident or telling staff that it was for the resident's safety and protection. During an interview with the DON on 6/25/24 at 11:00 AM, she verified that based on her investigation it was likely that someone restrained Resident #1 in the wheelchair with a sheet on 6/9/24, because the resident had recently been combative and had slid down in the wheelchair. She stated that she was unable to determine who had restrained the resident. The DON stated that she felt that they had done it for the resident's safety and did not feel that the resident was at risk of any injuries related to being restrained in the wheelchair with a sheet. During further interview the DON verified that there were no wedges listed as interventions on Resident #1's	M 500		

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M 500	Continued From page 12 "Daily Care Guide" and agreed that there were no physician's orders for the use of a mattress with elevated sides or wedges for Resident #1. During an interview with the Unit Manager (UM) on 6/25/24 at 1:16 PM, she revealed that a resident should never have any restraints applied without assessment , physicians' orders, and family consent. She stated restraining a resident places the resident at risk of sliding in the chair and getting choked. Record review of the "Face Sheet" revealed the facility admitted Resident #1 on 5/6/2024, with diagnoses that include Dementia and Impulse Disorder.	M 500		