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 12/20/2019

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

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F 000	INITIAL COMMENTS	F 000		

CI MS #16231 & CI MS #16451

The State Agency (SA) conducted a Complaint Survey investigating CI MS #16231, beginning 12/18/19 through 12/20/19. Concerns identified in the complaint for sampled Resident #1 were related to 1) unknown bruise to head, 2) weight loss, 3) no day clothes and resident had to wear other resident's clothing to a doctor's appointment, 4) staff wearing name tag backwards to prevent identification, 5) hair matted, 6) two pressure sores on legs, 7) not honoring preference for orange drinks, and 8) staff using resident bathroom. These concerns were not substantiated, and no deficiencies were cited.

The State Agency (SA) conducted a second complaint investigation for CI MS #16451, beginning 12/18/19 through 12/20/19. Concerns identified in the complaint were related to possible abuse and inappropriate transfer of Resident #1(not the same Resident #1 in CI MS #16231). Specific concerns included: 1) alleged physical abuse by staff and 2) inappropriate transfer of a resident. These concerns were not substantiated, and no deficiencies were cited.

The SA did determine the facility was not in compliance with the requirements of participation for Medicare and Medicaid, and cited F550 due to a concern identified with dignity during a transfer from the bed to a wheelchair with a stand up mechanical lift.

The facility had a census of 109 at the time of the complaint survey, and held certification for 120

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

Electronically Signed | 01/22/2020

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F 000	Continued From page 1	F 000		
	beds.			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be	F 550		1/23/20

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F 550	Continued From page 2 free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to maintain dignity for one (1) of two (2) residents observed during transfer using a lift, Resident #5. Findings include: Review of the facility's "Resident Bill of Rights" policy, revised 11/17, revealed, "Each resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the Facility in a manner and in an environment that promotes maintenance or enhancement of (his or her) quality of life, regardless of diagnosis, severity of condition or payment source and to exercise those rights as a citizen of the United States without interference, coercion, including those rights specified herein. A. Facility residents shall have the right to:..34. To personal privacy and confidentiality in his or her accommodations, personal and medical treatments and records, written telephone communications, personal care, visits and meetings of family and resident groups". On 12/19/19, at 11:03 AM, an observation of transfer for Resident #5 from the bed using a stand lift revealed that Certified Nursing Assistant (CNA) #1 was lying on the bed clothed in a hospital type gown and an incontinent brief. The door to the room was open. CNA #1 walked to the	F 550	Please consider this Plan of Correction as Ruleville Nursing and rehabilitation Center, LLC credible allegation of compliance. This plan of correction constitutes a written allegation of substantial compliance under Federal Medicare and Medicaid requirements. Submission of this plan of correction is not an admission that a deficiency exist or that the facility agrees they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our Residents and are submitted solely as a requirement of the provisions of Federal and State Law. 1. Resident #5 had no ill effects from Certified Nursing Assistant (CNA)failure to maintain dignity while providing transfer with the lift. CNA #1 was in-serviced on December 19, 2019 by the Staff Development Coordinator (SDC)to ensure that Residents' dignity is maintained while providing transfer assistance with the lift. The Maintenance Director immediately checked Resident #5 room door and repaired the inner thumb knob December 19, 2020 so that door would properly open and close.	

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F 550	Continued From page 3 door and pushed it closed but it immediately swung back open. CNA #1 removed the resident's gown, which revealed her bare torso and assisted the resident to don a shirt and pants which were pulled up to the resident's knees. CNA #1 assisted Resident #5 to sit on the side of the bed and attached the lift sling and stood resident up from the bed with her pants around her knees and an incontinent brief on. CNA #1 pulled the resident's pants up and sat Resident #5 in her wheelchair. On 12/19/19, at 11:08 AM, an interview with CNA #1, she stated, "I messed up. I was in a hurry". CNA #1 stated that it would be important to have the door to the room closed for privacy. CAN #1 stated that she closed it, but the lock was jammed and that she would have to push something in front of it to keep it closed. She stated that she was working fast and did not have time to put something in front of the door. She stated that the door would not stay closed for about two (2) weeks and she thought someone had reported it but was not sure. In an interview with the Director of Nursing (DON) on 12/19/19, at 11:40 AM, she stated that it was a privacy and dignity issue and that CNA #1 should have closed the door during personal care. The DON stated that the problem with the door closing should have been reported to someone and that she was unaware of the problem. Review of the Face Sheet for Resident #5 revealed that the resident was admitted to the facility on 8/1/19 with a diagnosis of Schizoaffective Disorder, Bipolar Type. Record review of the Minimum Data Set, with an Assessment Reference Date (ARD) of 10/31/19, revealed that the resident had a Brief Interview	F 550	2. All Residents who require transfers with a lift have the potential to be affected. 3. An in-service was initiated on December 19, 2019 by the Staff Development Coordinator for nursing staff to ensure that Residents' dignity is maintained when transfers are being done with the use of a lift. The Maintenance Director completed a 100% audit of all Residents' room doors on December 20, 2019 to ensure doors were operable to maintain dignity. No other concerns were identified. 4. The Director of Nursing and/or Registered Nursing (R.N.)Supervisor will conduct random rounds and audit three times week time four weeks beginning December 23, 2019 to ensure that Residents' dignity is maintained when transfers with lifts are being utilized. Any concerns will immediately be addressed. The Maintenance Director will conduct random rounds and audit doors weekly time four weeks beginning December 23, 2019 to ensure that Residents' room doors are operable to maintain dignity. Any concerns will be immediately addressed. The Director of Nursing and the Maintenance Director will forward the results of the audits from weekly rounds to the Executive Director beginning December 30, 2019. The Executive Director will forward the audit results to the monthly Quality Assurance Committee beginning January 30, 2020. The Quality Assurance Committee will determine the	

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F 550	Continued From page 4 for Mental Status score of 99 and a staff assessment of mental status of moderately impaired, decisions poor, cues/supervision required.	F 550	frequency or discontinuation of audits based upon the results achieved.	