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 _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RULEVILLE NURSING AND REHABILITATION CENTER LLC	800 STANSEL DR/P O BOX 368 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 an annual recertification along with complaint investigations, MS #15873 and MS #15850, from 4/29/19 to 5/2/19. During the survey, the SA determined the facility was not in compliance with the requirements of participation for Medicare and Medicaid. The SA did not substantiate MS #15850 and MS #15873 for allegations related to Quality of Care. The SA cited deficient practice at F578, F623, F641 and F656. The census at the time of the survey was 107, and the facility held a license for 111.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives	F 578		5/30/19

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

Electronically Signed | 05/25/2019

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 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.

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F 578	Continued From page 1 and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review the facility failed to accurately document a resident's choice related to the Advance Directives for one (1) of 26 residents reviewed for code status; Resident #102. Findings include: A review of the facility's "Advance Directives" policy, revealed, it is the policy of the facility to respect the resident's right of self-directed care including the right to issue Advance Directives on health care. Review of Resident # 102's medical record revealed, a Do Not Resuscitate (DNR) Advance Directive signed by Resident 102's representative on 4/4/19. The chart also had a signed physician	F 578	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. The April 2019 comprehensive printed orders for Resident #102 was corrected	

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F 578	Continued From page 2 order for DNR. The comprehensive printed orders for April 2019, revealed an order dated 4/5/19 for a Full Code. An interview on 04/30/19 at 03:12 PM, with Registered Nurse (RN) #2, revealed, she stated, we check the charts by the sticker and the physician's printed orders. Upon review of Resident # 102's Advance Directive and written order for DNR, RN #2 confirmed the printed order for a Full Code was wrong and needed to "fix it". An interview on 04/30/19 at 03:25 PM, with Licensed Practical Nurse (LPN) #4, 3:00 pm-11:00 pm cart nurse, revealed she would always check the physician printed orders for the advance directive orders. An interview on 4/30/19 at 3:28 PM, with LPN #3, 7:00 am-3:00 pm cart nurse, revealed, he checked the printed physician orders for the code status. An interview on 04/30/19 at 03:50 PM, with RN #1, 3:00 pm-11:00 pm cart nurse, revealed he always checked the written physician order in the front of the chart. RN #1 stated, the sticker on the chart or the printed orders could be incorrect just from human error.	F 578	on 04/30/2019 by the Director of Nurses to reflect Resident's choice for Do Not Resuscitate (DNR). Registered Nurse #2 was immediately in-serviced on 04/30/19 by the Director of Nurses on ensuring that documentation accurately reflects a Resident choice related to Advance Directives for code status. Resident #102 had no ill effects from this deficient practice. 2. All Residents have the potential to be affected by this deficient practice. 3. An in-service was initiated on 05/02/19 by the Director of Nurses for licensed nurses on ensuring that documentation accurately reflects a Resident's choice related to Advance Directives for code status. A 100% audit was conducted on 04/30/19 by the Director of Nurses to ensure that documentation accurately reflects a Resident choice related to Advance Directives for code status. No other concerns were identified. 4. The Director of Nurses began auditing on 05/03/19 30 charts per week x four weeks to ensure accuracy of documentation to reflect Residents' choices related to Advance Directive for code status. Any concerns will be immediately corrected. The Director of Nurses will forward the results of the audits to the Executive Director. The Executive Director will forward the results of the audits to the monthly Quality Assurance Committee. The monthly Quality Assurance Committee will determine frequency and continuation of audits based upon the results achieved and make recommendations as needed.	

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F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		5/30/19

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F 623	Continued From page 4 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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F 623	Continued From page 5 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to notify the State Ombudsman regarding residents transfer to the hospital for four (4) of four (4) residents reviewed for hospitalization; Resident #96, #73, #63, and #88. Findings include: A review of the facility statement, undated, signed by the Administrator, revealed the facility did not have a policy to send written notifications to the Ombudsman for transfers and discharges. Resident #88 A review of Resident #88's medical record, revealed: a physician's order dated 2/11/19 at 5:15 AM, to transfer resident to (Name of Hospital) Emergency Room (ER) for evaluation, treatment and possible admission.	F 623	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. The Social Service Director notified the State Ombudsman on 05/03/19 of Resident #96's hospital transfer on 01/13/19, Resident # 73's hospital transfer	

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F 623	Continued From page 6 The facility did not provide any documentation related to written notification of the Ombudsman regarding Resident #88's transfer. An interview with Social Services (SS), on 05/01/19 at 3:43 PM, revealed, she was not aware it was her responsibility to send the written notification to the Ombudsman. SS stated, she thought the Minimum Data Set (MDS) nurse sent the form to the family, and also to the Ombudsmen. SS stated, she was made aware just today to notify the Ombudsman monthly. An interview with Director of Nursing (DON), on 05/01/19 at 01:03 PM, confirmed the facility completed the written notification to the family. Resident #73 Review of the Minimum Data Set (MDS), dated 2/24/19, revealed, Resident #73 was discharged to the hospital on 2/24/19 and returned to the facility on 2/25/19. Review of the nurse progress notes dated 2/24/19, revealed, Resident #73 had a decreased level of consciousness (LOC) with no verbal response or response to stimuli, a temperature of 101.1 degrees, oxygen (O2) saturation was 81% and the resident was transferred to the hospital. Review of the Hospital Discharge Summary, revealed, the resident presented to the Emergency Room (ER) on 2/23/19 with acute Shortness of Breath (SOB) and pain in the chest and tightness. On 5/1/19 at 10:25 AM, an interview with the Administrator, revealed, the facility does not have a list to notify the Ombudsmen when the	F 623	on 02/24/19, Resident #63's hospital transfer on 03/14/19 and Resident # 88's hospital transfer on 02/11/19. The Social Service Director was in-serviced on 05/02/19 by the Executive Director on sending written notifications to the State Ombudsman for Resident transfers and discharges. Resident #96, #73, #63 and #88 had no ill effects from this deficient practice. 2. All Residents have the potential to be affected by this deficient practice. 3. An in-service was initiated on 05/03/19 by the Executive Director for Social Services and Minimum Data Set (MDS) Nurses on ensuring that the State Ombudsman is notified of Residents' transfers to the hospital. The Social Service Director completed monthly logs for May 2018 through April 2019 and submitted them to the State Ombudsman on May 03, 2019. 4. The Executive Director will audit the monthly State Ombudsman logs for hospital transfers and discharges monthly x two to ensure monthly logs are being submitted. Any concerns will be immediately corrected. The Executive Director will forward the results of the audits to the monthly Quality Assurance Committee. The Quality Assurance Committee will determine the frequency and continuation of audits based upon the results achieved and make recommendations as needed.	

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F 623	Continued From page 7 residents are transferred or discharged to the hospital. On 5/1/19 at 3:45 PM, an interview with Social Worker (SW) #1, revealed, she had not been sending notifications to the Ombudsman regarding transfers to the hospital. SW #1 stated, she thought the Minimum Data Set (MDS) nurse was sending the notifications to the Ombudsman. SW #1 stated, she found out today that she was responsible for written notification of transfers/discharges to the Ombudsman. Resident #96 Record review for Resident #96, revealed, the resident was discharged from the facility to the hospital on 1/13/19 and returned to the facility on 1/18/19. The nurse progress notes, dated 1/13/19, revealed, the resident was admitted to (Name of Hospital) with diagnosis of Gastrointestinal (GI) Bleed. The MDS assessment with an Assessment Reference Date (ARD) of 2/24/19, revealed a Discharge Return Anticipated was completed for Resident #96 due to another hospitalization. The Hospital Discharge Summary, with a dictation date of 3/5/19, indicated, the resident was admitted to the hospital on 2/24/19 and discharged on 3/5/19 with diagnoses which included Pneumonia, Volume Depletion and Hypokalemia. On 4/29/19 at 12:13 PM, an interview with the Resident Representative for Resident #96, revealed, Resident #96 had been in the hospital for "Pneumonia."	F 623		

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F 623	Continued From page 8 Resident #63 A record review for Resident #63, revealed a physician's order, dated 3/14/19 at 9:30 AM, to transport resident to (Name of Hospital) ER for evaluation and treatment and possible admission related to lethargy, hallucination and decreased level of consciousness. On 05/01/19 at 10:25 AM, an interview with the Administrator, revealed, the facility had not been notifying the Ombudsman monthly of residents being transferred to the hospital. On 05/01/19 at 04:25 PM, an interview with the Administrator, revealed, the facility did not have a policy regarding sending a notice to the Ombudsman when a resident went out to the hospital.	F 623		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, observation, and facility policy review the facility failed to accurately code the Minimum Data Set (MDS) for five (5) of 28 resident MDS assessments reviewed; Residents #107, #88, #5, #96 and #64. Findings include: Review of the Centers for Medicare and Medicaid	F 641	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	5/30/19

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F 641	Continued From page 9 (CMS) MDS 3.0 Resident Assessment (RAI) Manual, revealed, the federal regulations require the assessment accurately reflects the resident's status. Review of a facility's "MDS Assessment" policy, dated 11/17, revealed, the facility shall conduct interdisciplinary assessments using the MDS item sets as defined by Federal/State regulations. The assessment was to provide information on the resident's condition to facilitate the development of an individualized plan on care. Resident #107 Review of Resident 107's Admission MDS assessment with an Assessment Reference Date (ARD) of 1/17/19, revealed, Section A1500 was coded "NO" to indicate resident evaluated by Pre-Admission Screening and Resident Reviews (PASRR) and Section A1510A was "BLANK" for Serious Mental Illness. An interview, on 05/02/19 at 8:37 AM, with Licensed Practical Nurse (LPN) #2/MDS Coordinator, confirmed, the MDS with an ARD date of 1/17/19, for Resident #107, revealed, Section A1500 was coded "NO" and Section A1510A was coded "Blank" . She said the Resident Assessment Manual (RAI) was the source of the information they use to complete the MDS. LPN #2 confirmed, Resident #107 had a diagnosis of Schizophrenia. An interview, with LPN #1/MDS Coordinator, on 5/2/19 at 8:40 AM, revealed, she stated, they usually ask the business office if the PASRR was done.	F 641	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. Minimum Data Set (MDS)with Assessment Reference Date (ARD)for Resident #5 was corrected on 04/30/19 by Licensed Practical Nurse (LPN) #2. MDS with ARD of 03/07/19 for Resident #64 was corrected by LPN #2 on 05/03/19. MDS with ARD of 04/08/19 for Resident #96 was corrected on 05/23/19. MDS with ARD of 01/17/19 for Resident #107 was corrected on 05/23/19 by LPN #2. MDS with ARD of 01/15/19 for Resident #88 was corrected on 05/23/19 by LPN #2. Resident #5, #64, #96, #107 and #88 had no ill effects from this deficient practice. LPN #2 was in-serviced on 05/03/19 by the Director of Nurses on ensuring that the Minimum Data Set (MDS) is accurately coded to reflect the Resident's Status. 2. All Residents have the potential to be affected by this deficient practice. 3. The Director of Nurses in-serviced the Interdisciplinary Team (MDS Nurses, Activities, Dietary, and Social Services) on 05/03/19 to ensure that the MDS is accurately coded to reflect the Residents' status. A 100% audit was completed by May 10, 2019 for any MDS completed for March 1, 2019 through April 30, 2019 by LPN #2 to ensure accuracy. No other concerns were identified. 4. Starting May 3, 2019, any MDS	

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F 641	Continued From page 10 Review of Resident #107's "PASRR Notice of Nursing Facility Approval", dated 3/21/19, indicated the resident met the criteria for having a diagnosis of mental illness as defined by PASRR, with a diagnosis of Schizophrenia, which met the requirement for Serious Mental Illness. Resident #88 Review of Resident 88's MDS assessment, with an ARD date of 1/15/19, revealed Section A1500, Resident evaluated by Pre-Admission Screening and Resident Reviews (PASRR), was coded "NO" and Section A1510A, Serious Mental Illness was coded "Blank". An interview, on 05/02/19 at 8:37 AM, with LPN #2/MDS Coordinator, confirmed, the MDS with an ARD date of 1/15/19, for Resident #88, revealed, Section A1500 was coded "NO" and Section A1510A was coded "Blank". LPN #2 stated, the RAI Manual was the source of the information they use to complete the MDS. LPN #2 confirmed, Resident #88 had a diagnosis of Schizophrenia. An interview, with LPN #1/MDS Coordinator, on 5/2/19 at 8:40 AM, revealed, she stated, they usually ask the Business Office if the PASRR was done. Review of Resident # 88's, "PASRR Notice of Nursing Facility Approval", dated 4/5/17, indicated the resident met the criteria for having a diagnosis of mental illness as defined by PASRR, with a diagnosis of Schizophrenia, in which met the criteria of Serious Mental Illness.	F 641	completed will be audited weekly x four weeks by the MDS Coordinator and/or MDS Assistant to ensure accuracy of assessments. Any concerns will be immediately corrected. The MDS Coordinator will forward the results of the audits to the Executive Director. The Executive Director will forward the results of the audits to the monthly Quality Assurance Committee. The Quality Assurance Committee will determine the frequency and continuation of the audits based upon the results achieved and make recommendations as needed.	

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	255113	A. BUILDING _____ B. WING _____	05/02/2019

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RULEVILLE NURSING AND REHABILITATION CENTER LLC	800 STANSEL DR/P O BOX 368 RULEVILLE, MS 38771

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F 641	Continued From page 11 Resident #5 An observation and interview, on 04/29/19 at 10:55 AM, revealed, Resident # 5 had a brace to his left wrist. Resident #5 stated, he received the brace after a fall. Review of Resident #5 physician's orders, dated 4/11/19, revealed, an order for a brace to left forearm at all times and may remove for shower and Activities of Daily Living (ADL) care. Review of Resident # 5's Quarterly MDS, with an ARD date of 4/16/19, revealed no impairment of the upper extremities under Section G0400A. An interview, on 05/02/19 at 8:20 AM, with LPN #2, revealed, she completed Resident #5's Quarterly MDS, with the ARD date of 4/16/19. LPN #2 stated, the fracture of Resident #5's wrist and the change in Range of Motion (ROM), should have been captured on Resident # 5's MDS, dated 4/16/19. LPN #2 confirmed, Section G0400A was coded for no impairment. LPN #2 stated, with a fracture in the left wrist, it would limit Resident #5's ROM on one side of his upper extremity. LPN #2 also confirmed, the MDS was not accurate to Resident #5's current status. An interview, on 5/2/19 at 8:37 AM, with LPN #1, revealed, she stated, they follow the Resident Assessment Instrument (RAI) for instructions on completing the MDS. Resident #64 A review of the facility's "MDS Assessment" policy, with the most recent revision date of 11/17, revealed, the interdisciplinary team member's signatures in Z0400 will attest to	F 641		

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F 641	Continued From page 12 completion/accuracy of the assessment. A record review of the most recent Yearly MDS assessment, with an Assessment Reference Date (ARD) of 3/7/19, revealed, Section N0410E was coded to indicate an anticoagulant was received by Resident #64 for seven (7) days. A review of the March 2019 physician's orders, revealed, there was no anticoagulant medication ordered. On 4/30/19 at 3:53 PM, an interview with LPN #1, revealed, the most recent comprehensive Yearly MDS assessment, with an ARD of 3/7/19, was coded to include an anticoagulant. Upon LPN #1 reviewing the Medication Administration Record (MAR), for the month of March 2019, she stated, she did not see an anticoagulant medication ordered for Resident #64. LPN #1 stated, she would not say that the MDS assessment was coded accurately. On 5/1/19 at 9:50 AM, an interview with LPN #2, revealed, after she closed the MDS, she could have gone back and reviewed the MDS. On 5/1/19 at 10:33 AM, an interview with the Director of Nursing (DON), revealed, she would expect the staff to code the MDS as accurately as they know how to do. On 5/1/19 at 8:30 AM, an interview with LPN #1, revealed, both MDS nurses use the Resident Assessment Manual (RAI) as a guideline to complete the MDS. Resident #96	F 641		

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F 641	Continued From page 13 A review of the most recent Quarterly MDS assessment, with an ARD of 4/8/19, revealed, Section K0300 was coded to indicate weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. This MDS assessment also was coded under Section K0310, to include weight gain of 5% or more in the last month or gain of 10% or more in the last 6 months. A review of Resident #96 weights, over the past six months, revealed, he weighed 161.0 pounds (lbs) on 11/7/18. He had a weight of 133.0 lbs as of 4/25/19. On 5/1/19 at 10:45 AM, an interview with the Dietary Manager, revealed, "Oh, that is not coded right (referring to the MDS), he (referring to Resident #96) could not have a weight loss and a weight gain at the same time.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		5/30/19

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F 656	Continued From page 14 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review the facility failed to revise the comprehensive care plan to reflect the change of limited range of motion (ROM) for Resident #5; for one (1) of two (2) residents reviewed with limited range of motion. Findings include: Review of the facility's "Comprehensive Person Center Care Plan" policy, dated 3/18, revealed that upon a change in condition, the	F 656	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	

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F 656	Continued From page 15 comprehensive care plan will be updated. Review of Resident #5's physician orders, dated 4/11/19, revealed, an order for a brace to left forearm at all times and may remove for shower and Activities of Daily Living (ADL) daily. Review of Resident #5's comprehensive care plan, revealed, no revision or addition of the change in the resident's ROM; nor was there a problem indicated in the comprehensive care plan to address ROM or ADLs. Review of Resident #5's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/16/19, revealed, no impairment of the upper extremities under Section G0400A. An observation and interview, on 04/29/19 at 10:55 AM, revealed, Resident #5 had a brace to the left wrist. Resident #5 stated, he received the brace after a fall. An interview, on 05/02/19 at 08:20 AM, with Licensed Practical Nurse (LPN) #2, revealed, she completed Resident #5's Quarterly MDS assessment, with the ARD date of 4/16/19. LPN #2 stated, the fracture of Resident #5's left wrist and the change in Range of Motion (ROM), should have been captured on Resident #5's MDS dated 4/16/19. LPN #2 confirmed, the MDS Section G0400A was coded to indicate no impairment. LPN #2 stated, that with a fracture to the left wrist, it would limit Resident #5's ROM on one side of his upper extremity. LPN #2 confirmed, the MDS was not accurate to Resident #5's current status. LPN #2 stated, the care plan triggers with the MDS, which would trigger on limited ROM; and should have had a care plan	F 656	of care and services provided to our Residents and are submitted solely as a requirement of the provisions of Federal and State Law. 1. A comprehensive care plan for range of motion (ROM) was developed on 05/03/19 by Licensed Practical Nurse (LPN) #2 for Resident #5. Resident #5 had no ill effects from this deficient practice. LPN #2 was in-serviced on 05/03/19 by the Director of Nurses on revising comprehensive care plans to reflect the change of limited range of motion (ROM) triggered by a change of condition. 2. All Residents have the potential to be affected by this deficient practice. 3. An in-service was completed on 05/03/19 by the Director of Nurses for the Interdisciplinary Team (MDS Nurses, Activities, Dietary and Social Services) on ensuring that comprehensive care plans are reflective of Resident's status. A 100% audit was completed by May 10, 2019 for any Minimum Data Set (MDS) completed for March 1, 2019 through April 30, 2019 by LPN #2 to ensure accuracy of comprehensive care plans to reflect Resident's status. No other concerns were identified. 4. Starting May 03, 2019 MDS Coordinator and/or MDS Assistant will randomly audit 20 charts per week x four weeks to ensure that comprehensive care plans are reflective of Residents' status. Any concerns will be immediately corrected. The MDS Coordinator will forward the results of the audits to the	

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F 656	Continued From page 16 related to the brace and limited ROM. LPN #2 stated, the comprehensive care plan should have been completed on 4/30/19, but was unable to update because of survey in the building.	F 656	Executive Director. The Executive Director will forward the results of the audits to the monthly Quality Assurance Committee. The Quality Assurance Committee will determine the frequency and continuation of audits based upon the results achieved and make recommendations as needed.	

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	255113	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/02/2019**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		

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

Electronically Signed | 05/29/2019

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 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.

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E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 5/2/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

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