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 _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RULEVILLE NURSING AND REHABILITATION (	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) COMPLETE DATE
M 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 Minimum Standards for the Aged or Infirm. The SA did not substantiate MS #15850 and MS #15873 for allegations related to Quality of Care. The SA cited deficient practice at M735. The census at the time of the survey was 107, and the facility held a license for 111.	M 000		
M 735	45.25.1 Medical Records Management Medical Records Management. 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam;	M 735		5/30/19

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 _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RULEVILLE NURSING AND REHABILITATION (	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) COMPLETE DATE
M 735	Continued From page 1 annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary, including the final diagnosis. 5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records. 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge. 8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years. 9. A resident index, including the resident's full name and birth date, shall be maintained. This Statute 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:	M 735	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	

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 _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RULEVILLE NURSING AND REHABILITATION C	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) COMPLETE DATE
M 735	Continued From page 2 Review of the facility's "Comprehensive Person Center Care Plan" policy, dated 3/18, revealed that upon a change in condition, the 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	M 735	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. 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 Director of Nurses on revising comprehensive care plan 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 Residents' 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' status. No other concerns were identified. 4. Starting May 3, 2019 the 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	

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 _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RULEVILLE NURSING AND REHABILITATION (	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) COMPLETE DATE
M 735	Continued From page 3 #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 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.	M 735	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.	