

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/16/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/21/2023
NAME OF PROVIDER OR SUPPLIER RULEVILLE NURSING AND REHABILITATION CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 800 STANSEL DR RULEVILLE, MS 38771		
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F 000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI), MS CI #20343, CI MS #20374, CI MS #20285, CI MS #20319, and CI MS #20488 at the facility from 1/9/23 to 1/21/23. During the survey, the SA determined that the facility was not in compliance with the requirements for participation in Medicare and Medicaid. An extended survey was completed, and the following deficiencies were cited for CI MS #20319 and CI MS #20343: F600, F623, F660, F835 at an Immediate Jeopardy (IJ) level for resident-to-resident abuse, discharge rights, facility administration, and discharge planning. The SA found no evidence of deficient practice for CI MS #20285, CI MS 20374 and CI MS #20488. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 9/8/22 when the facility failed to protect residents from a resident who had a history of resident-to-resident abuse. The facility failed to ensure a safe post-discharge destination and available caregiver support for Resident #1. This placed Resident #1, Resident #2 and Resident #8 in a situation that caused serious injury, serious harm and serious impairment and placed other residents at risk in a situation that would likely cause serious injury, harm, impairment, or death. On 1/17/23 at 1:30 PM, the SA notified the Administrator, Director of Nurses and Regional Vice President of the IJ and SQC and provided the facility with the IJ templates for F600, F623 and F660. On 1/18/23 at 1:00 PM, the SA notified the Administrator, DON and Regional Vice President and provided the IJ template for F835.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/10/2023

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 000	Continued From page 1 The SQC and IJ existed at: CFR 483.12 (a)(1) Abuse (F600)-Scope and Severity "J". IJ existed at: CFR 483.15 (c) (3) Notice Before Transfer (F623)-Scope and Severity "J". CFR 483.21 (c)(1)(i)(iv) Discharge Planning Process (F660)-Scope and Severity "J". CFR 483.70 Administration (F835)-Scope and Severity "J". The facility submitted an acceptable Removal Plan on 1/19/23, in which the facility alleged all corrective action to remove the IJ were completed on 1/19/23 and IJ removed on 1/19/23. The SA validated the Removal Plan on 1/21/23, and determined the IJ was removed on 1/19/23, prior to exit. Therefore, the scope and severity for CFR 483.12 (a)(1) Abuse (F600), CFR 483.15 (c) (3) Notice Before Transfer (F623), CFR 483.21 (c)(1)(i)(iv) Discharge Planning Process (F660), and CFR 483.70 Administration (F835) were lowered from a "J" to a "D", while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The facility is licensed for 111 beds and at the time of the survey the census was 109.	F 000			
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation	F 600		2/19/23	

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F 600	Continued From page 2 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 observation, record review, interviews, and facility policy/procedure review the facility failed to protect three (3) of 11 residents from abuse as evidenced by the failure to protect Resident #2 and Resident #8 of physical abuse from Resident #1 after Resident #1 physically attacked Resident #8 on 9/8/22 and Resident #2 on 12/22/22. On 12/26/22, Resident #1 was sent to Geri-psych for treatment and returned on 12/29/22 due to refusal to take his medications and treatment. He requested to go home to his Resident Representative's (RR) home and was discharged. The facility transported him to his RR's home without notifying the RR of the discharge. The RR was out of state and Resident #1 was left at the locked home in a chair on the front porch. The facility's failure to protect residents from resident-to-resident abuse and leaving Resident #1 outside of the RR's locked home placed Resident #1, Resident #2 and Resident #8 in a situation that caused serious injury, serious harm and serious impairment and placed other	F 600	1. Resident #8 was provided immediate protection by facility staff on 09/08/2022. Facility Charge Nurse #3 provided first-aid to resident #8 on 09/08/2022. Resident #8 was transferred to behavior health for evaluation and treatment on 09/08/2022. Resident #2 was provided immediate protection by facility on 12/22/2022. Resident #2 was sent to the hospital for treatment for nasal fracture and facial swelling on 12/22/2022 and returned to facility on 12/22/2022. Resident #1 was discharged on 12/29/2022. 2. All residents have the potential to be affected by this deficient practice. 3. On 01/17/2023 an in-service to licensed nurses and Social Services was started by the Staff Development Coordinator and the Director of Nursing on regarding safe and orderly discharge with sufficient instructions related to medications. This in-service was completed on 01/17/2023.		

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F 600	Continued From page 3 residents at risk in a situation that would likely cause serious injury, harm, impairment, or death. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 9/8/22 when Resident #1 physically attached Resident #8. On 1/17/23 at 1:30 PM, the SA notified the Administrator, Director Of Nurses and Regional Vice President of the IJ and SQC and provided the facility with the IJ template for F600. The facility submitted an acceptable Removal Plan on 1/19/23, in which the facility alleged all corrective action to remove the IJ were completed on 1/19/23 and IJ removed on 1/19/23. The SA validated the Removal Plan on 1/21/23, and determined the IJ was removed on 1/19/23, prior to exit. Therefore, the scope and severity for CFR 483.12 (a)(1) Abuse (F600) was lowered from a "J" to a "D", while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of the facility's "Abuse Prevention" policy last revised "7/18" revealed, "The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual. The facility Abuse	F 600	No licensed nurses or Social Worker will be allowed to work until in-serviced. 4. On 01/23/2023 the Director of Nursing started a resident discharge audit on residents who are discharged home to ensure residents are safely discharged with medications and care instructions. This will be completed (5) five times a week for (4) four weeks. On 01/25/2023 the Director of Nursing and the Staff Development Coordinator in-serviced facility staff on resident to resident altercations, abuse and neglect, and how to deal with residents with combative behavior. This in-service was completed on 01/27/2023. Starting on 01/26/2023 the Director of Nursing initiated the resident abuse audit to ensure residents with combative behavior are identified and interventions are placed by facility staff. This audit will be completed (5) five times a week for (4) four weeks. The Director of Nursing will forward the results of all audits to the Executive Director beginning on 01/26/2023. Starting on 01/27/2023 the Executive Director initiated monitoring of resident to resident audit for completeness and accuracy weekly times (4) four weeks then monthly times (1) one month. The Executive Director will forward the results of the audit findings to the Quality Assurance Committee monthly times (2) two months starting on 02/08/2023. The Quality Assurance Committee will review and make recommendations as deemed necessary and the results of audits and monitoring		

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F 600	Continued From page 4 Prevention policy defines "Abuse: Willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse may be resident-to-resident, staff-to-resident, family-to-resident, or visitor-to-resident." Record review of the Incident Log dates 7/15/22-1/9/23 revealed that Resident #1 was involved with six (6) resident-to-resident altercations in that time frame. Record review of the Incident Log revealed the first incident involving a physical altercation was on 9/8/22 between Resident #1 and Resident #8. The SA investigation revealed that Resident #8 accidentally ran over the foot of Resident #1 with his wheelchair. The altercation ended when Resident #1 hit Resident #8 in the face causing a 2 cm laceration above his left eyebrow. Resident #8 received in-house treatment and sent for an evaluation at a Geri-Psych unit. Resident #1 was sent for an evaluation at a Geri-Psych unit. Record review of the Facility Investigation revealed the physical altercation between Resident #1 and Resident #2 was on 12/22/22. Resident #1 and Resident #2 were roommates at that time. Resident #2 was observed by staff ambulating down the hall from his room towards the nurses station bleeding from his head. He stated that his roommate had hit him. Resident #1 was noted in his wheelchair, sitting near the dayroom. Resident #2 was immediately taken into an empty resident room for a physical evaluation, treatment and to begin questioning regarding the incident. Resident #1 was taken into his room and put one on one with a staff member. The staff member sitting with Resident	F 600	will be maintained in the Executive Director's office.		

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F 600	Continued From page 5 #1 noted blood on his hand. She began to question him about what happened, and Resident #1 wasn't speaking clear enough to be understood but she did understand that Resident #1 believed that Resident #2 had his television remote. Both residents were sent to the Emergency Room (ER) for evaluation and treatment. Resident #2 was treated for a broken nose, lacerations to his face and a black eye. He returned to the facility on 12/22/22. Resident #1 refused to leave the nursing home to go to the ER for an evaluation on 12/22/22. The Medical Director and his primary physician were notified. He did a now order for Ativan and Haldol injection to calm his agitation. He was then transported by Emergency Medical Technician (EMT)'s to the local hospital for evaluation and treatment. He stayed in the ER until 12/23/22 and was then transferred back to the nursing home. The nursing home put Resident #1 one on one with staff. The Social Worker (SW) was attempting to find a Geri-psych unit to accept him for evaluation and treatment if necessary. He stayed one on one through to transport to a Geri-psych unit on 12/26/22. The Stage Agency (SA) investigation revealed that Resident #1 was returned to the nursing home on 12/29/22 due to Resident #1 refused medications and treatment while in the Geri-psych until and was discharged from the unit on 12/29/22. He returned to the nursing home and refused to be readmitted stating he wanted to go to his Resident Representative's home. The Administrator instructed Resident #1 on discharge Against Medical Advice (AMA). He was not his own RR. The Business Office Manager (BOM) attempted three times to contact the RR by phone with no success. She stated she was	F 600			

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F 600	Continued From page 6 unable to leave a voice mail. Two staff members transported Resident #1 to his RR's home per the facility van. The staff members did not see a person at the home. Both staff members stated that Resident #1 had medications in a bag. There was a Ring doorbell system and a female voice said to facility staff that no one was at home. Facility staff left Resident #1 sitting in a chair on the front porch of the RR's home. Interview with the Administrator on 1/9/23 at 4:20 PM, revealed that Resident #1 had a physical altercation with Resident #2. Resident #2 had a broken nose and a black Left (L) eye. Resident #1 was sent to the local hospital due to his behaviors. He returned to the facility on 12/23/22 and was one on one with staff until 12/26/22. He was transferred to Geri psych on 12/26/22 and returned to the facility on 12/29/22 due to refusing medications and treatment. Record review of the hospital "Patient Discharge Instructions Page 2 of 3" for Resident #2 dated 12/22/22 revealed that his "Discharge Diagnosis" were "Abrasion (Rt (right) brow), Contusion (Rt orbit, Lt (left) orbit, Lt facia, Nasal septum), Fracture (Rt nasal bone)." Record review of the "CT (Computerized Tomography) CERVICAL SPINE W/O CONTRAST" dated 12/22/22 of Resident #2 revealed "Impression 2. Focal mild soft tissue swelling/contusion along the superolateral aspect of the right orbit. 3. Mild soft tissue swelling at the anterior nose with a subtle nondisplaced right nasal bone fracture. 4. Diffuse mild to moderate soft tissue swelling at the left upper face/inferior margin of the left orbit likely also representing contusion."	F 600			

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F 600	Continued From page 7 During an interview with the Administrator on 1/11/23 at 11:44 AM, she revealed that when Resident #1 was sent to the Geri-psych for evaluation and treatment on 12/26/22. The Administrator stated "We sent him with his medications to senior care. He returned with his same medications. I saw the meds with him when he returned here. The facility did not send him home with any medications. That's why there were no meds on the discharge summary." On 1/11/23 at 10:40 AM, in an interview with the Facility Transporter revealed that the Maintenance Assistant went with him to transfer Resident #1 to his RR's home in Byram, MS which is located approximately 2 to 2 1/2 hours from the nursing facility on 12/29/22 in the facility van. He stated "We didn't take any paperwork. Resident #1 had a bag of meds with him." He stated after arriving at the RR's home "a female talked through the Ring camera. She said a name, but I never understood it. No, he didn't go inside. He sat on the porch in front of the camera. The nursing home Administrator gave me the address of where to take him. I did call the facility saying there was no one coming to the door. I told the facility staff that someone was talking to me through the door Ring camera." He was unable to recall who he spoke to at the nursing home when he called to inform the facility that no one was coming to the door. On 1/11/23 at 10:55 AM, during an interview with the Maintenance Assistant on revealed he was with the Facility Transporter transferring Resident #1 to his RR's home. He stated "the Facility Transporter was talking to someone through the Ring doorbell. Yes, there was a zip-lock bag with	F 600			

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F 600	Continued From page 8 medications. They were his meds from the nursing home. Yes, I saw pills. The person speaking on the Ring camera said his sister was not there." He stated that Resident #1 was wearing a shirt, pants, shoes, socks, jacket, and hat. He stated that Resident #1 "was sitting in a chair on the front porch in front of the door when we left. His belongings were beside him." Observation and interview on 1/11/23 at 3:15 PM with Resident #8 revealed speech very difficult to understand. When the SA asked Resident #8 if he feared anyone in the facility, Resident #8 pointed to his left eye area and said he was scared of the man that scratched his face. Observation and interview on 1/11/23 at 3:30 PM with Resident #2 revealed he is "leery" of some residents. When the SA questioned Resident #2 further, he stated he "is only scared of Resident #1". During an interview with the Resident #1's RR on 1/12/23 at 8:31 AM, revealed that she was not home when the nursing home van dropped Resident #1 off at her house. She stated she was out of state at the time. She stated, "I had to call 911 and the police and ambulance had to come. There was no one home when they left him. The house was locked. I had not been contacted by the nursing home prior to him coming home." She did state that there had been a family conference "24 days earlier" and discharge of Resident #1 was discussed. She stated, the administrator said 'well, he's got to go". She said Resident #1 does have behaviors if "provoked". She revealed that the police contacted an ambulance service and Resident #1 was admitted to the hospital and remains there at	F 600			

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F 600	Continued From page 9 this time. She stated it took the police 2 hours to get to her residence to make initial contact with Resident #1. Interview with the Director of Nurses (DON) on 1/12/23 at 2:35 PM revealed that she was in the facility during the resident-to-resident altercation between Resident #1 and Resident #2. She stated that LPN #1 came and got her around "4:30 PM" and that as she went down "west hall", she saw Resident #2 with blood on his face and clothes with the "right side of his face swollen, nose bleeding and blood all over his face." She said that she and LPN #2 took Resident #1 into the closest room for an evaluation and treatment. She stated Resident #2 said "My roommate jumped on me". She stated that as she was taking Resident #2 into that room, she saw CNA #1 with Resident #1. CNA #1 took Resident #1 back to his room. "I called (name of medical director) and got an order to send Resident #2 to the ER. He had a puncture under his right eye, open areas on scalp, bleeding and fractured nose." CNA#1 stayed in the room with Resident #1 and "told me she found blood on the floor in their room" "blood on knuckles on both of Resident #1's hands." "I asked Resident #1 if he hit someone and he said 'yeah, I hit him, he had my remote control and wouldn't give it back.'" The DON stated the Administrator had called the police. The Medical Director gave an order to send Resident #1 to the ER for evaluation due to behaviors. Resident #1 refused to leave with the Emergency Medical Technicians (EMT) when they arrived to take him. The medical director was notified and ordered a "Now" order for Ativan and Haldol injection. She stated that Resident #1 was calmer and went to the ER with the EMT's. The DON confirmed that she and the Administrator	F 600			

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F 600	Continued From page 10 both called the RR of Resident #1. The DON stated that Resident #1 returned to the facility on 12/23/22 and was one on one until he was sent to Geri-psych on 12/26/22. She stated that Resident #1 was put in a private room until Geri-psych placement on 12/26/22. Interview with LPN #2 on 1/12/23 at 3:18 PM, revealed that she was working on 12/22/22 and saw Resident #2 standing by the DON and "was bloody". LPN #2 went into the room with the DON and Resident #2 for an assessment. She stated that she saw Resident #1 after Resident #2 had left to go to the hospital. Resident #1 stated "he wouldn't give me my remote", when LPN #2 asked what happened. She stated police returned to help in case Resident #1 refused the Ativan and Haldol injection. Resident #1 took the injection without problem after talking with the police. She stated that staff was with Resident #1 one on one until he went to Geri-psych on 12/26/22. Record review of Resident #1's Face Sheet revealed he was readmitted to the facility on 9/1/22. His admitting diagnosis included Schizophrenia, Bipolar Disorder, Other Seizures, Hypothyroidism. Record review of Resident #1's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/4/22 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. Record review of Resident #1's care plans revealed he is care planned for behaviors of suicidal ideations, pacing, easily agitated, verbally/physically aggressive, hallucinations,	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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F 600	Continued From page 11 paranoid thinking. Record review of Resident #8's Face Sheet revealed he was admitted to the facility on 11/27/18. His diagnoses include Schizophrenia, Major depressive disorder, Alzheimer's disease, Extrapyramidal and movement disorder, Unspecified Dementia with other behavioral disturbances, Anxiety disorder. Record review of Resident #8's quarterly MDS assessment with an Assessment Reference Date of 12/21/22 and revealed a Brief Interview for Mental Status (BIMS) was 3, indicating severe cognitive impairment. Record review of Resident #2's Face Sheet revealed he was admitted to the facility on 5/2/22. His diagnoses include Schizophrenia, Parkinson's disease, Anxiety disorder, Major depressive disorder, Unspecified Dementia without behaviors. Record review of Resident #2's quarterly MDS with an Assessment Reference Date of 10/28/22 and revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognitive skills. The facility provided an acceptable Removal Plan on 1/19/23. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ: Removal Plan: Failure Statement: Facility failed to ensure residents were protected from physical abuse when Resident #1, who had	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 600	Continued From page 12 a pattern and history of aggression, assaulted Resident #2 and #8 causing injury. The facility failed to ensure Resident #1 was transferred/discharged in a safe orderly manner with sufficient instruction related to medications. Facility failed to ensure Resident #1 Responsible Representative was notified of detailed discharge planning, and arrangements for post-discharge care including medication instruction. Summary: On 09/08/2022 Resident #1 began having episodes of aggression. Resident #1 was involved in a physical altercation with resident #8 who was the aggressor. Resident #8 sustained a laceration to the right eyebrow. Resident #1 was transferred to Geri-psych #1 and Resident #8 was transferred to Geri-psych #2. Resident #8 was assessed by Charge Nurse #3. First aide was provided by Charge Nurse #3 prior to transfer to Geri-psych #2. On 12/22/2022 Resident #1 was involved in an altercation with Resident #2 resulting in injury to nose and face. Residents #1 and #2 were assessed by Director of Nursing and Charge Nurse #1 prior to sending to Hospital for evaluation. Resident #1 was returned to facility on 12/23/22 and placed on one-on-one observation. Resident #2 was treated at hospital for nasal fracture and facial swelling and returned to facility on 12/22/2022 at 9:09 p.m. Resident #1 remained on one-on-one observation at facility until discharged to Geri-psych #1 on 12/26/2022 for evaluation and treatment. He returned to facility on 12/29/2022 at which time he refused to be readmitted to facility and signed himself out Against Medical Advice. Facility transported resident to sisters' home at his request on	F 600			

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F 600	Continued From page 13 12/29/2022 at 1:30 p.m. by facility transporters in the facility van with two attendants. Resident #1 was left unattended. Resident #1 had a zip lock bag with medication on his person when returned from Geri-Psych #1. Resident #1 medications were not reconciled by facility due to resident #1 refusal to readmit to facility. Medical Director was notified of Resident #1 leaving facility Against Medical Advice on 12/29/2022 at 2:36p.m. by Staff Development Coordinator. Ombudsman notified of Resident #1 leaving facility Against Medical Advice on 12/29/2022 at 5:52 p.m. by Administrator. Facility's action: 1. Abuse and neglect in-service for all staff completed by Staff Development Coordinator in-servicing starting on 12/22/22 through 12/25/22. The staff verbalized understanding the importance of protecting all residents from abuse to include resident to resident abuse and how to deal with combative residents. No staff will be allowed to work until completion of in-service. 2. Licensed nurses, and Social Services in-serviced on safe and orderly discharge with sufficient instruction related to medications will be completed by 01/17/23 by Staff Development, Director of Nursing and Administrator. Social Services or licensed nursing staff will not be allowed to work until in-serviced. On 01/12/2023 through 1/14/2023 an Staff Development Nurse in-serviced Minimum Data Set Nurse, Social Services, and Nursing Service on baseline care plan policy. 3. Resident #1 was placed on one on one observation starting 12/22/22 while in facility until	F 600			

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F 600	Continued From page 14 transferred to Geri-psych hospital for evaluation 12/26/22. Then returned from Geri-psych #1 on 12/29/22 and Resident #1 left Against Medical Advice prior to readmission. 4. Head to toe assessment was completed on Resident #8 by Charge Nurse #3 on 09/08/2022. Head to toe assessments of Residents #1 and #2 was completed by Charge Nurse #1 and Director of Nursing on 12/22/22. On 09/08/22, Resident #8 received in-house treatment of injury to right eyebrow and was later transferred to Geri-psych #2 for psych evaluation on 09/08/22 at 7:11 a.m. Residents #1 and #2 were sent to hospital for evaluation and treatment 12/22/22. 5. All residents were assessed for post traumatic issues related to abuse or neglect by Social Services, this was completed on 12/23/2022. No other residents were identified. 6. On 1/17/23, Staff Development Coordinator, Director of Nursing, and Administrator in-serviced Licensed nurses to ensure sufficient instruction will be given to resident or their representative related to discharge medications. 7. Administrator and Director of Nursing in-serviced on safe and orderly discharge with medications and not to leave any residents unattended or unsupervised when transferring a resident by Regional Vice President on 01/13/2023. 8. Social Services and facility van transporters in-serviced on safe and orderly discharge with medications and not to leave any residents unattended or unsupervised when transferring a	F 600			

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F 600	Continued From page 15 resident. Staff Development Coordinator completed an in-service 1/17/23 by 5 p.m. Social Service or van drivers will not be allowed to transport or transfer any resident until in-service is completed. 9. Disciplinary counseling completed on Administrator for failure to ensure Resident Representative was notified of discharge of Resident #1. Failure to ensure safe discharge of Resident #1 with medication reconciliation. Completed by Regional Vice President on 01/13/2023. 10. All residents discharged home was audited from July 15, 2022 through 12/29/2022 to ensure safe discharge with medication and care instruction. Only 1 resident was discharged home during this time frame, there were no issues noted. This audit was completed by Director of Nursing on 01/13/2023. Quality Assurance: 1. An emergency Quality Assurance Performance Improvement Committee meeting was held on 12/22/2022 at 9:30 a.m. until 10:30 a.m. to review the resident-to-resident abuse between Resident #1 and #2. In attendance was Administrator, Director of Nursing, Minimum Data Set Nurse, RN Unit Manager, Medical Records, Infection Control Nurse, House Keeping Supervisor, Social Service Director, Maintenance Director, Business Office Manager, Staff Development Nurse, and Medical Director. There were no new recommendations or changes made to policies. Abuse in-service completed for all staff, and Resident to Resident Abuse Audit Tool initiated.	F 600			

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F 600	Continued From page 16 2. Facility held a second emergency Quality Assurance Performance Improvement Committee meeting on 01/17/2023 4:00p.m. to review immediate jeopardy F-tag .600, F623, F660. In attendance was Administrator, Director of Nursing, Minimum Data Set Nurse, Medical Records, Infection Control Nurse, House Keeping Supervisor, Social Service Director, Maintenance Director, Business Office Manager, Staff Development Nurse, and Medical Director. Reviewed discharge look back from 07/15/2022 through 12/29/22 audit was performed Director of Nursing. One issues noted. There were no new recommendations or changes made to policies. Abuse in-service completed for all staff, and Resident to Resident Abuse Audit Tool initiated. 3. Facility held a third emergency Quality Assurance Performance Improvement Committee was held on 01/18/2023 at 3:30 p.m. to review immediate jeopardy F-tag 835. In attendance was Administrator, Director of Nursing, Minimum Data Set Nurse, Medical Records, Infection Control Nurse, House Keeping Supervisor, Social Service Director, Maintenance Director, Business Office Manager, Staff Development Nurse, and Medical Director. Reviewed Safe Discharge policies and medications. No issues or concerned voiced. There were no new recommendations. The facility alleges compliance as reported to the Department of Health on 1/19/2023. VALIDATION: On 1/21/23, the SA validated the facility had implemented the following measures to remove	F 600			

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F 600	Continued From page 17 the Immediate Jeopardy. The Removal Plan was verified by staff interviews and record reviews of in-services. 1. Record review and staff interviews on 1/21/23 confirmed the facility had conducted Abuse and neglect in-service for all staff completed by Staff Development Coordinator in-servicing starting on 12/22/22 through 12/25/22. During staff interviews on 1/21/23, staff verbalized understanding the importance of protecting all residents from abuse to include resident to resident abuse and how to deal with combative residents. No staff will be allowed to work until completion of in-service. 2. Record review and staff interviews on 1/21/23 confirmed that Licensed nurses, and Social Services were in-serviced on safe and orderly discharge with sufficient instruction related to medications completed by 01/17/23 by Staff Development, Director of Nursing and Administrator. Social Services or licensed nursing staff will not be allowed to work until in-serviced. On 01/12/2023 through 1/14/2023 an Staff Development Nurse in-serviced Minimum Data Set Nurse, Social Services, and Nursing Service on baseline care plan policy. 3. Record review and interview on 1/21/23 confirmed that Resident #1 was placed on one on one observation starting 12/22/22 while in facility until transferred to Geri-psych hospital for evaluation 12/26/22. Then returned from Geri-psych #1 on 12/29/22 and Resident #1 left Against Medical Advice prior to readmission.	F 600			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 600	Continued From page 18 4. Record review and staff interview on 1/21/23 confirmed that a Head-to-toe assessment was completed on Resident #8 by Charge Nurse #3 on 09/08/2022. Head to toe assessments of Residents #1 and #2 was completed by Charge Nurse #1 and Director of Nursing on 12/22/22. On 09/08/22, Resident #8 received in-house treatment of injury to right eyebrow and was later transferred to Geri-psych #2 for psych evaluation on 09/08/22 at 7:11 a.m. Residents #1 and #2 were sent to hospital for evaluation and treatment 12/22/22. 5. Record review and staff interviews on 1/21/23 confirmed that all residents were assessed for post traumatic issues related to abuse or neglect by Social Services, this was completed on 12/23/2022. No other residents were identified. 6. Staff interviews and record review on 1/21/23 confirmed that on 1/17/23, Staff Development Coordinator, Director of Nursing, and Administrator in-serviced Licensed nurses to ensure sufficient instruction will be given to resident or their representative related to discharge medications. 7. Record review and staff interviews on 1/21/23 confirmed that the Administrator and Director of Nursing in-serviced on safe and orderly discharge with medications and not to leave any residents unattended or unsupervised when transferring a resident by Regional Vice President on 01/13/2023. 8. Staff interview and record review on 1/21/23 confirmed that Social Services and facility van transporters were in-serviced on safe and orderly	F 600			

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F 600	Continued From page 19 discharge with medications and not to leave any residents unattended or unsupervised when transferring a resident. Staff Development Coordinator completed an in-service 1/17/23 by 5 p.m. Social Service or van drivers will not be allowed to transport or transfer any resident until in-service is completed. 9. Staff interview and record review on 1/21/23 confirmed that Disciplinary counseling completed on Administrator for failure to ensure Resident Representative was notified of discharge of Resident #1. Failure to ensure safe discharge of Resident #1 with medication reconciliation. Completed by Regional Vice President on 01/13/2023. 10. Record review and staff interviews on 1/21/23 confirmed that all residents discharged home was audited from July 15, 2022 through 12/29/2022 to ensure safe discharge with medication and care instruction. Only 1 resident was discharged home during this time frame, there were no issues noted. This audit was completed by Director of Nursing on 01/13/2023. Record review and staff interviews on 1/21/23 confirmed that an emergency Quality Assurance Performance Improvement Committee meeting was held on 12/22/2022 at 9:30 a.m. until 10:30 a.m. to review the resident-to-resident abuse between Resident #1 and #2. In attendance was Administrator, Director of Nursing, Minimum Data Set Nurse, RN Unit Manager, Medical Records, Infection Control Nurse, House Keeping Supervisor, Social Service Director, Maintenance Director, Business Office Manager, Staff Development Nurse, and Medical Director. There were no new recommendations or changes made	F 600			

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F 600	Continued From page 20 to policies. Abuse in-service completed for all staff, and Resident to Resident Abuse Audit Tool initiated. Staff interviews and record review on 1/21/23 confirmed that the facility held a second emergency Quality Assurance Performance Improvement Committee meeting on 01/17/2023 4:00p.m. to review immediate jeopardy F-tag .600, F623, F660. In attendance was Administrator, Director of Nursing, Minimum Data Set Nurse, Medical Records, Infection Control Nurse, House Keeping Supervisor, Social Service Director, Maintenance Director, Business Office Manager, Staff Development Nurse, and Medical Director. Reviewed discharge look back from 07/15/2022 through 12/29/22 audit was performed Director of Nursing. One issues noted. There were no new recommendations or changes made to policies. Abuse in-service completed for all staff, and Resident to Resident Abuse Audit Tool initiated. Record review and staff interviews on 1/21/23 confirmed that the facility held a third emergency Quality Assurance Performance Improvement Committee was held on 01/18/2023 at 3:30 p.m. to review immediate jeopardy F-tag 835. In attendance was Administrator, Director of Nursing, Minimum Data Set Nurse, Medical Records, Infection Control Nurse, House Keeping Supervisor, Social Service Director, Maintenance Director, Business Office Manager, Staff Development Nurse, and Medical Director. Reviewed Safe Discharge policies and medications. No issues or concerned voiced. There were no new recommendations. Staff interviewed on 1/21/23 were seven (7)	F 600			

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F 600	Continued From page 21 Certified Nurse Aides (CNA), two (2) Registered Nurses (RN), three (3) Licensed Practical Nurses (LPN), one (1) Business Office Manager (BOM), 1 Social Worker (SW), 1 Minimum Data Set LPN, 1 Administrator, 1 Director of Nurses, 2 Covid Screeners.	F 600			
F 623 SS=J	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	F 623		2/19/23	

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F 623	Continued From page 22 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 (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	F 623			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/16/2023
FORM APPROVED
OMB NO. 0938-0391

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F 623	Continued From page 23 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. 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, interviews and policy/procedure review the facility failed to notify the Resident Representative (RR) of Resident #1's discharge and failed to provide the reasons in writing and in a language and manner they understand for one (1) of five (5) discharged residents sampled. The facility's failure to notify Resident #1's (RR) at the time of the discharge placed Resident #1 in a situation that would likely cause serious injury, harm, impairment, or death.	F 623	1. Resident #1 returned to facility on 12/29/2022 at which time Resident #1 refused to be readmitted to facility and signed self out Against Medical Advice. On 12/29/2022 the facility transported Resident #1 upon request to Responsible Representative's home by facility transporters. As of 12/29/2022 Resident #1 is no longer a resident at this facility. 2. All residents have the potential to be affected by this practice.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 623	Continued From page 24 The SA identified an Immediate Jeopardy (IJ) that began on 12/29/22 when the facility failed to ensure a safe discharge for Resident #1. Two (2) staff members transported Resident #1 to his RR 's home per the facility van. The staff members did not see a person at the home. Both staff members stated that Resident #1 had medications in a bag. There was a Ring doorbell system and a female voice said to facility staff that no one was at home. The facility staff left Resident #1 sitting in a chair on the front porch of the RR's home. On 1/17/23 at 1:30 PM, the SA notified the Administrator, Director Of Nurses and Regional Vice President of the IJ and provided the facility with the IJ template. The IJ existed at: CFR 483.15 (c) (3) Discharge Rights (F623)-Scope and Severity "J". The facility submitted an acceptable Removal Plan on 1/19/23, in which the facility alleged all corrective action to remove the IJ were completed on 1/19/23 and IJ removed on 1/19/23. The SA validated the Removal Plan on 1/21/23, and determined the IJ was removed on 1/19/23, prior to exit. Therefore, the scope and severity for CFR 483.15 (c) (3) Discharge Rights (F623), was lowered from a "J" to a "D", while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include:	F 623	3. On 01/23/2023 the Staff Development Coordinator and the Director of Nursing provided in-servicing to licensed nurses and Social Services regarding notifying the Resident Representative of detailed discharge planning and arrangements for post-discharge care including safe and orderly discharge with sufficient instructions related to medications. This in-service was completed on 01/23/2023, and no licensed nurses or Social Workers will be allowed to work until in-serviced. On 01/23/2023 the Director of Nursing started a discharge audit, regarding notifying Resident Representative of detailed discharge planning and arrangements for post-discharge care including safe and orderly discharge with sufficient instructions related to medications. 4. The discharge audit will completed (5) five times a week for (4) four weeks, then weekly for (4) four weeks on residents who are discharged home to ensure residents are safely discharged with medications and care instructions. Starting on 01/27/2023 the Executive Director initiated monitoring of the discharge audit for completeness and accuracy weekly times (4) four weeks then monthly times (1) one month. The Executive Director will forward the results to the Quality Assurance Committee meeting monthly times (2) two starting on 02/08/2023. The Quality Assurance Committee will review for any further recommendations as deemed necessary. Results of audits and monitoring will be		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/16/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/21/2023
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F 623	Continued From page 25 Record review on 1/12/23 of the facility's "Discharge and transfer policies-Involuntary" policy/procedure, last revised "7/18" revealed the "Responsibility: All staff, monitored by the Director of Nursing and Executive Director." The "Procedure: 4. The facility will provide sufficient orientation to residents to ensure safe and orderly transfer or discharge from the facility including an opportunity to participate in deciding where to go." Policy/procedure of the facility's "Discharge Medications" last revised 8/16 revealed the policy "Discharge Medications Policy: Medications are sent with the resident upon discharge only under conditions that protect the resident and ensure compliance with the law." Record review of the Care Plan with a problem onset date of 06/17/2019 revealed, "Problem/Need: I/Rp (Responsible party) desired length of stay is long term. I/Rp and care planning team have determined that d/c (discharge) to community is not feasible. Goal and Target Date: Resident/Rp goal/desire: Plan/desire is to remain in this facility through NRD (next review date)...10/22 CPOC (continue Plan of Care) thru 1/23..." Record review of the facility investigation revealed, "...Facility will utilize appropriate action to discharge (formal name of resident) to another institution to meet his needs..." Record review of the Face Sheet revealed Resident # 1 was readmitted to the facility on 9/1/22. His admitting diagnosis included Schizophrenia, Bipolar Disorder, Other Seizures, Hypothyroidism.	F 623	maintained in the Executive Director's office.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 623	Continued From page 26 Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) was 10/4/22 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #1 was cognitively intact. Record review of the care plan revealed for behaviors of suicidal ideations, pacing, easily agitated, verbally/physically aggressive, hallucinations, paranoid thinking. Record review of the medical record for Resident #1 revealed he had returned to the facility on 12/29/22 from a Geri-psych unit admission on 12/26/22. He was discharged from the Geri-psych unit on 12/29/22 due to refusal to take medications and participate in his treatment. He arrived at the nursing home and refused to go to his room. He was requesting to discharge from the nursing home and go to his RR ' s home in Byram, Ms. The facility attempted three (3) times to contact the RR with no success. Resident #1 was transported in the nursing homes van by 2 staff members to the RR's home and left outside the home, unattended. Review of the internet site www.wunderground.com for the weather in Byram, MS on 12/29/22 revealed the temperature high-73 degrees Fahrenheit (F), low temperatures 58 degrees F, zero (0) rain and the maximum winds were 20 Miles Per Hour (MPH). Record review of Resident #1's "Discharge Summary/Instructions" dated 12/29/22, revealed there are no medications listed as being sent home with the resident and there is nothing listed under the "Education regarding	F 623			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 623	Continued From page 27 medications/treatments, exercises, or other services" sections of the Discharge Summary. Interview with the Administrator on 1/11/23 at 11:44 AM, revealed that when Resident #1 was sent to the Geri-psych for evaluation and treatment on 12/26/22. The Administrator stated "We sent him with his medications to senior care. He returned with his same medications. I saw the meds with him when he returned here. The facility did not send him home with any medications. That's why there were no meds on the discharge summary." Interview with the Facility Transporter on 1/11/23 at 10:40 AM, revealed that the Maintenance Assistant went with him to transfer Resident #1 to his RR ' s home in Bryam, MS on 12/29/22 in the facility van. He stated "We didn ' t take any paperwork. Resident #1 had a bag of meds with him." He stated after arriving at the RR ' s home "a female talked through the Ring camera. She said a name, but I never understood it. No, he didn ' t go inside. He sat on the porch in front of the camera. The nursing home Administrator gave me the address of where to take him. I did call the facility saying there was no one coming to the door. I told the facility staff that someone was talking to me through the door Ring camera." He was unable to recall who he spoke to at the nursing home when he called to inform the facility that no one was coming to the door. Interview with the Maintenance Assistant on 1/11/23 at 10:55 AM, revealed he was with the Facility Transporter transferring Resident #1 to his RR ' s home. He stated "the Facility Transporter was talking to someone through the Ring doorbell. Yes, there was a zip-lock bag with	F 623			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 623	Continued From page 28 medications. They were his meds from the nursing home. Yes, I saw pills. The person speaking on the Ring camera said his sister was not there." He stated that Resident #1 was wearing a shirt, pants, shoes, socks, jacket, and hat. He stated that Resident #1 "was sitting in a chair on the front porch in front of the door when we left. His belongings were beside him." The SA conducted an interview with the RR of Resident #1 on 1/12/23 at 8:31 AM, revealed that she was not home when the nursing home van dropped Resident #1 off at her house. She stated she was out of state at the time. She stated, "I had to call 911 and the police and ambulance had to come. There was no one home when they left him. The house was locked. I had not been contacted by the nursing home prior to him coming home." She did state that there had been a family conference "24 days earlier" and discharge of Resident #1 was discussed. She stated, the Administrator said "Well, he's got to go". She said Resident #1 does have behaviors if "provoked". She revealed that the police contacted an ambulance service and Resident #1 was admitted to the hospital and remains there at this time. She stated it took the police 2 hours to get to her residence to make initial contact with Resident #1. Interview with the facility Business Office Manager (BOM) on 1/12/23 at 1:42 PM, revealed that when Resident #1 returned from the Geri-psych unit on 12/29/22, he came into her office. She stated "(name of Administrator) came in and talked to him and he said he wanted to go home to Drew, MS. He then said take him to his sister 's house and gave (name of administrator) the phone number. I was looking at his Face	F 623			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 623	Continued From page 29 Sheet and he gave the right number for his sister/RR. I called her number 2 or three times. I didn ' t get an answer. The voicemail wouldn ' t let me leave a message. He kept saying he wanted to go to his sister's house. Interview with the facility Housekeeping Supervisor on 1/12/23 at 1:55 PM, revealed he was in the BOM ' s office on 12/29/22 when Resident #1 said he wanted to go home. He stated "he was agitated, saying he wanted to go home. (Name of BOM) tried to call the (RR) with no answer a couple of times. They offered to take him to his room. The Administrator said for him to let her read a paper to him about leaving AMA. He signed it, said he understood it. He left in the facility van to go home. Interview with Licensed Practical Nurse (LPN) #2 on 1/12/23 at 3:18 PM, revealed that she contacted the Medical Director/Resident #1 ' s primary physician to let him know that Resident #1 wanted to go home. "I called (name of Medical Director/Primary Physician) and let him know Resident #1 wanted to go home to his sister ' s home and needed an order for Home Health and the discharge. He said Ok. Resident #1 had already left when I called (name of Medical Director/Primary Physician). Interview with the Medical Director and Primary Physician at 1:20 PM on 1/12/23, revealed that he was unaware the facility van left Resident #1 on his RR's front steps without anyone at home. Interview with the Administrator on 1/13/23 at 12:10 PM, revealed "We never sent a 30 day discharge letter related to Resident #1. We discussed it after a meeting with his RR/sister but	F 623			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 623	Continued From page 30 decided against it. We wanted to wait on that." Failure Statement: Facility failed to ensure residents were protected from physical abuse when Resident #1, who had a pattern and history of aggression, assaulted Resident #2 and #8 causing injury. The facility failed to ensure Resident #1 was transferred/discharged in a safe orderly manner with sufficient instruction related to medications. Facility failed to ensure Resident #1 Responsible Representative was notified of detailed discharge planning, and arrangements for post-discharge care including medication instruction. Summary: On 09/08/2022 Resident #1 began having episodes of aggression. Resident #1 was involved in a physical altercation with resident #8 who was the aggressor. Resident #8 sustained a laceration to the right eyebrow. Resident #1 was transferred to Geri-psych #1 and Resident #8 was transferred to Geri-psych #2. Resident #8 was assessed by Charge Nurse #3. First aide was provided by Charge Nurse #3 prior to transfer to Geri-psych #2. On 12/22/2022 Resident #1 was involved in an altercation with Resident #2 resulting in injury to nose and face. Residents #1 and #2 were assessed by Director of Nursing and Charge Nurse #1 prior to sending to Hospital for evaluation. Resident #1 was returned to facility on 12/23/22 and placed on one-on-one observation. Resident #2 was treated at the hospital for nasal fracture and facial swelling and returned to facility on 12/22/2022 at 9:09 p.m. Resident #1 remained	F 623			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 623	Continued From page 31 on one-on-one observation at facility until discharged to Geri-psych #1 on 12/26/2022 for evaluation and treatment. He returned to facility on 12/29/2022 at which time he refused to be readmitted to facility and signed himself out Against Medical Advice. Facility transported resident to sisters ' home at his request on 12/29/2022 at 1:30 p.m. by facility transporters in the facility van with two attendants. Resident #1 was left unattended. Resident #1 had a zip lock bag with medication on his person when returned from Geri-Psych #1. Resident #1 medications were not reconciled by facility due to resident #1 refusal to readmit to facility. Medical Director was notified of Resident #1 leaving facility Against Medical Advice on 12/29/2022 at 2:36p.m. by Staff Development Coordinator. Ombudsman notified of Resident #1 leaving facility Against Medical Advice on 12/29/2022 at 5:52 p.m. by Administrator. Facility's action: 1.Abuse and neglect in-service for all staff completed by Staff Development Coordinator in-servicing starting on 12/22/22 through 12/25/22. The staff verbalized understanding the importance of protecting all residents from abuse to include resident to resident abuse and how to deal with combative residents. No staff will be allowed to work until completion of in-service. 2.Licensed nurses, and Social Services in-serviced on safe and orderly discharge with sufficient instruction related to medications will be completed by 01/17/23 by Staff Development, Director of Nursing and Administrator. Social Services or licensed nursing staff will not be	F 623			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 623	Continued From page 32 allowed to work until in-serviced. On 01/12/2023 through 1/14/2023 an Staff Development Nurse in-serviced Minimum Data Set Nurse, Social Services, and Nursing Service on baseline care plan policy. 3. Resident #1 was placed on one-on-one observation starting 12/22/22 while in facility until transferred to Geri-psych hospital for evaluation 12/26/22. Then returned from Geri-psych #1 on 12/29/22 and Resident #1 left Against Medical Advice prior to readmission. 4. Head to toe assessment was completed on Resident #8 by Charge Nurse #3 on 09/08/2022. Head to toe assessments of Residents #1 and #2 was completed by Charge Nurse #1 and Director of Nursing on 12/22/22. On 09/08/22, Resident #8 received in-house treatment of injury to right eyebrow and was later transferred to Geri-psych #2 for psych evaluation on 09/08/22 at 7:11 a.m. Residents #1 and #2 were sent to hospital for evaluation and treatment 12/22/22. 5. All residents were assessed for post traumatic issues related to abuse or neglect by Social Services, this was completed on 12/23/2022. No other residents were identified. 6. On 1/17/23, Staff Development Coordinator, Director of Nursing, and Administrator in-serviced Licensed nurses to ensure sufficient instruction will be given to resident or their representative related to discharge medications. 7. Administrator and Director of Nursing in-serviced on safe and orderly discharge with	F 623			

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F 623	Continued From page 33 medications and not to leave any residents unattended or unsupervised when transferring a resident by Regional Vice President on 01/13/2023. 8. Social Services and facility van transporters in-serviced on safe and orderly discharge with medications and not to leave any residents unattended or unsupervised when transferring a resident. Staff Development Coordinator completed an in-service 1/17/23 by 5 p.m. Social Service or van drivers will not be allowed to transport or transfer any resident until in-service is completed. 9. Disciplinary counseling completed on Administrator for failure to ensure Resident Representative was notified of discharge of Resident #1. Failure to ensure safe discharge of Resident #1 with medication reconciliation. Completed by Regional Vice President on 01/13/2023. 10. All resident ' s discharged home was audited from July 15, 2022, through 12/29/2022 to ensure safe discharge with medication and care instruction. Only 1 resident was discharged home during this time frame, there were no issues noted. This audit was completed by Director of Nursing on 01/13/2023. Quality Assurance: 1. An emergency Quality Assurance Performance Improvement Committee meeting was held on 12/22/2022 at 9:30 a.m. until 10:30 a.m. to review the resident-to-resident abuse between Resident #1 and #2. In attendance	F 623			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/16/2023
FORM APPROVED
OMB NO. 0938-0391

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F 623	Continued From page 34 was Administrator, Director of Nursing, Minimum Data Set Nurse, RN Unit Manager, Medical Records, Infection Control Nurse, House Keeping Supervisor, Social Service Director, Maintenance Director, Business Office Manager, Staff Development Nurse, and Medical Director. There were no new recommendations or changes made to policies. Abuse in-service completed for all staff, and Resident to Resident Abuse Audit Tool initiated. 2. Facility held a second emergency Quality Assurance Performance Improvement Committee meeting on 01/17/2023 4:00p.m. to review immediate jeopardy F-tag .600, F623, F660. In attendance was Administrator, Director of Nursing, Minimum Data Set Nurse, Medical Records, Infection Control Nurse, House Keeping Supervisor, Social Service Director, Maintenance Director, Business Office Manager, Staff Development Nurse, and Medical Director. Reviewed discharge look back from 07/15/2022 through 12/29/22 audit was performed Director of Nursing. One issue noted. There were no new recommendations or changes made to policies. Abuse in-service completed for all staff, and Resident to Resident Abuse Audit Tool initiated. 3. Facility held a third emergency Quality Assurance Performance Improvement Committee was held on 01/18/2023 at 3:30 p.m. to review immediate jeopardy F-tag 835. In attendance was Administrator, Director of Nursing, Minimum Data Set Nurse, Medical Records, Infection Control Nurse, House Keeping Supervisor, Social Service Director, Maintenance Director, Business Office Manager, Staff Development Nurse, and Medical Director. Reviewed Safe Discharge policies and medications. No issues or concerns voiced.	F 623			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 623	Continued From page 35 There were no new recommendations. The facility alleges compliance as reported to the Department of Health on 1/19/2023. VALIDATION: 1. Record review and staff interviews on 1/21/23 confirmed the facility had conducted Abuse and neglect in-service for all staff completed by Staff Development Coordinator in-servicing starting on 12/22/22 through 12/25/22. During staff interviews on 1/21/23, staff verbalized understanding the importance of protecting all residents from abuse to include resident to resident abuse and how to deal with combative residents. No staff will be allowed to work until completion of in-service. 2. Record review and staff interviews on 1/21/23 confirmed that Licensed nurses, and Social Services were in-serviced on safe and orderly discharge with sufficient instruction related to medications completed by 01/17/23 by Staff Development, Director of Nursing and Administrator. Social Services or licensed nursing staff will not be allowed to work until in-serviced. On 01/12/2023 through 1/14/2023 an Staff Development Nurse in-serviced Minimum Data Set Nurse, Social Services, and Nursing Service on baseline care plan policy. 3. Record review and interview on 1/21/23 confirmed that Resident #1 was placed on one-on-one observation starting 12/22/22 while in facility until transferred to Geri-psych hospital for evaluation 12/26/22. Then returned from Geri-psych #1 on 12/29/22 and Resident #1 left Against Medical Advice prior to readmission.	F 623			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 623	Continued From page 36 4. Record review and staff interview on 1/21/23 confirmed that a Head-to-toe assessment was completed on Resident #8 by Charge Nurse #3 on 09/08/2022. Head to toe assessments of Residents #1 and #2 was completed by Charge Nurse #1 and Director of Nursing on 12/22/22. On 09/08/22, Resident #8 received in-house treatment of injury to right eyebrow and was later transferred to Geri-psych #2 for psych evaluation on 09/08/22 at 7:11 a.m. Residents #1 and #2 were sent to hospital for evaluation and treatment 12/22/22. 5. Record review and staff interviews on 1/21/23 confirmed that all residents were assessed for post traumatic issues related to abuse or neglect by Social Services, this was completed on 12/23/2022. No other residents were identified. 6. Staff interviews and record review on 1/21/23 confirmed that on 1/17/23, Staff Development Coordinator, Director of Nursing, and Administrator in-serviced Licensed nurses to ensure sufficient instruction will be given to resident or their representative related to discharge medications. 7. Record review and staff interviews on 1/21/23 confirmed that the Administrator and Director of Nursing in-serviced on safe and orderly discharge with medications and not to leave any residents unattended or unsupervised when transferring a resident by Regional Vice President on 01/13/2023. 8. Staff interview and record review on 1/21/23 confirmed that Social Services and facility van transporters were in-serviced on safe and orderly	F 623			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 623	Continued From page 37 discharge with medications and not to leave any residents unattended or unsupervised when transferring a resident. Staff Development Coordinator completed an in-service 1/17/23 by 5 p.m. Social Service or van drivers will not be allowed to transport or transfer any resident until in-service is completed. 9. Staff interview and record review on 1/21/23 confirmed that Disciplinary counseling completed on Administrator for failure to ensure Resident Representative was notified of discharge of Resident #1. Failure to ensure safe discharge of Resident #1 with medication reconciliation. Completed by Regional Vice President on 01/13/2023. 10. Record review and staff interviews on 1/21/23 confirmed that all residents discharged home was audited from July 15, 2022 through 12/29/2022 to ensure safe discharge with medication and care instruction. Only 1 resident was discharged home during this time frame, there were no issues noted. This audit was completed by Director of Nursing on 01/13/2023. Record review and staff interviews on 1/21/23 confirmed that an emergency Quality Assurance Performance Improvement Committee meeting was held on 12/22/2022 at 9:30 a.m. until 10:30 a.m. to review the resident-to-resident abuse between Resident #1 and #2. In attendance was Administrator, Director of Nursing, Minimum Data Set Nurse, RN Unit Manager, Medical Records, Infection Control Nurse, House Keeping Supervisor, Social Service Director, Maintenance Director, Business Office Manager, Staff Development Nurse, and Medical Director. There were no new recommendations or changes made	F 623			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 623	Continued From page 38 to policies. Abuse in-service completed for all staff, and Resident to Resident Abuse Audit Tool initiated. Staff interviews and record review on 1/21/23 confirmed that the facility held a second emergency Quality Assurance Performance Improvement Committee meeting on 01/17/2023 4:00p.m. to review immediate jeopardy F-tag .600, F623, F660. In attendance was Administrator, Director of Nursing, Minimum Data Set Nurse, Medical Records, Infection Control Nurse, House Keeping Supervisor, Social Service Director, Maintenance Director, Business Office Manager, Staff Development Nurse, and Medical Director. Reviewed discharge look back from 07/15/2022 through 12/29/22 audit was performed Director of Nursing. One issue noted. There were no new recommendations or changes made to policies. Abuse in-service completed for all staff, and Resident to Resident Abuse Audit Tool initiated. Record review and staff interviews on 1/21/23 confirmed that the facility held a third emergency Quality Assurance Performance Improvement Committee was held on 01/18/2023 at 3:30 p.m. to review immediate jeopardy F-tag 835. In attendance was Administrator, Director of Nursing, Minimum Data Set Nurse, Medical Records, Infection Control Nurse, House Keeping Supervisor, Social Service Director, Maintenance Director, Business Office Manager, Staff Development Nurse, and Medical Director. Reviewed Safe Discharge policies and medications. No issues or concerns voiced. There were no new recommendations. Staff interviewed on 1/21/23 were seven (7)	F 623			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 623	Continued From page 39 Certified Nurse Aides (CNA), two (2) Registered Nurses (RN), three (3) Licensed Practical Nurses (LPN), one (1) Business Office Manager (BOM), 1 Social Worker (SW), 1 Minimum Data Set LPN, 1 Administrator, 1 Director of Nurses, 2 Covid Screeners.	F 623			
F 660 SS=J	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and	F 660		2/19/23	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 660	Continued From page 40 resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident	F 660			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 660	Continued From page 41 information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review, interviews and facility policy/procedure review the facility failed to transition a Resident to post-discharge care for one (1) of five (5) discharged residents sampled. Resident #1 The facility failed to ensure Resident #1 had available caregiver support and a safe post-discharge destination, failed to notify the Resident Representative (RR) of Resident #1's discharge, and failed to provide instructions on post discharge care and medications. The SA identified an Immediate Jeopardy (IJ) that began on 12/29/22 when the facility failed to ensure a safe discharge for Resident #1. Two (2) staff members transported Resident #1 to his RR's home per the facility van. The staff members did not see a person at the home. Both staff members stated that Resident #1 had medications in a bag. There was a Ring doorbell system and a female voice said to facility staff that no one was at home. The facility staff left Resident #1 sitting in a chair on the front porch of the RR's home. On 1/17/23 at 1:30 PM, the SA notified the Administrator, Director of Nurses and Regional Vice President of the IJ and provided the facility with the IJ template. The IJ existed at: CFR 483.21 (c) (1) Discharge Planning	F 660	1. On 12/26/2022 Resident #1 was transferred to the behavior unit for evaluation and treatment. Resident #1 returned to the facility on 12/29/2022 at which time Resident #1 refused to be readmitted to facility and signed self out Against Medical Advice. On 12/29/2022 the facility transported Resident #1 upon request to Resident Representative's home by facility transporters. Resident #1 was discharge from facility on 12/29/2022. 2. All residents have the potential to be affected by this deficient practice. 3. On 01/17/2023 Staff Development Coordinator, Director of Nursing, and Executive Director in-serviced facility van drivers on transporting residents home with medications. On 01/23/2023 the Staff Development Coordinator and the Director of Nursing in-serviced licensed nurses and Social Services regarding safe and orderly discharge with sufficient instructions related to medications. No licensed nurses or Social Workers will be allowed to work until in-serviced. 4. On 01/23/2023 the Director of Nursing started a resident discharge audit and van driver audit weekly times (4) four weeks then monthly times (1) one month on		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 660	Continued From page 42 (F660)-Scope and Severity "J". The facility submitted an acceptable Removal Plan on 1/19/23, in which the facility alleged all corrective action to remove the IJ were completed on 1/19/23 and IJ removed on 1/19/23. The SA validated the Removal Plan on 1/21/23, and determined the IJ was removed on 1/19/23, prior to exit. Therefore, the scope and severity for CFR 483.21 (c) (1) Discharge Planning (F660) was lowered from a "J" to a "D", while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Record review on of the facility's "Discharge and transfer policies-Involuntary" policy/procedure, last revised "7/18" revealed the "Responsibility: All staff, monitored by the Director of Nursing and Executive Director." The "Procedure: 4. The facility will provide sufficient orientation to residents to ensure safe and orderly transfer or discharge from the facility including an opportunity to participate in deciding where to go." Record review of the Policy/procedure of the facility's "Discharge Medications" last revised "8/16" revealed the policy. "Discharge Medications Policy: Medications are sent with the resident upon discharge only under conditions that protect the resident and ensure compliance with the law." Record review of the Care Plan with a problem	F 660	residents who discharged home to ensure residents are safely discharged with medications and care instructions. Starting on 01/27/2023 the Executive Director initiated monitoring of discharge audit for discrepancies weekly times (4) four weeks then monthly times (1) one month. The Executive Director will forward the results of the monitoring to the Quality Assurance Committee meeting monthly times (2) two months starting on 02/08/2023. The Quality Assurance Committee will review for any recommendations as deemed necessary and the results of audits and monitoring will be maintained in the Executive Director's office.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 660	Continued From page 43 onset date of 06/17/2019 revealed, "Problem/Need: I/Rp (Responsible party) desired length of stay is long term. I/Rp and care planning team have determined that d/c (discharge) to community is not feasible. Goal and Target Date: Resident/Rp goal/desire: Plan/desire is to remain in this facility through NRD (next review date)...10/22 CPOC (continue Plan of Care) thru 1/23..." Record review of the facility investigation revealed, "...Facility will utilize appropriate action to discharge (formal name of resident) to another institution to meet his needs..." Record review of the Face Sheet revealed Resident # 1 was readmitted to the facility on 9/1/22. His admitting diagnosis included Schizophrenia, Bipolar Disorder, Other Seizures, Hypothyroidism. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) was 10/4/22 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #1 was cognitively intact. Record review of the care plan revealed for behaviors of suicidal ideation, pacing, easily agitated, verbally/physically aggressive, hallucinations, paranoid thinking. His Responsible Party (RP) was his sister. Record review of the medical record revealed Resident #1 had returned to the facility on 12/29/22 from a Geri-psych unit admission on 12/26/22. He was discharged from the Geri-psych unit on 12/29/22 due to refusal to take medications and participate in his treatment. He	F 660			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 660	Continued From page 44 arrived at the nursing home and refused to go to his room. He was requesting to discharge from the nursing home and go to his RR's home in Byram, Ms. The facility attempted three (3) times to contact the RR with no success. Resident #1 was transported in the nursing homes van by 2 staff members to the RR's home and left outside the home, unattended. Review of Internet site "www.wunderground.com on 1/12/23 for the weather in Byram, MS on 12/29/22 revealed the temperature high-73 degrees Fahrenheit (F), low temperatures 58 degrees F, zero (0) rain and the maximum winds were 20 Miles Per Hour (MPH). Record review of Resident #1's "Discharge Summary/Instructions" dated 12/29/22, revealed there are no medications listed as being sent home with the resident and there is nothing listed under the "Education regarding medications/treatments, exercises, or other services" sections of the Discharge Summary. Interview with the Administrator on 1/11/23 at 11:44 AM, revealed that when Resident #1 was sent to the Geri-psych for evaluation and treatment on 12/26/22. The Administrator stated "We sent him with his medications to senior care. He returned with his same medications. I saw the meds with him when he returned here. The facility did not send him home with any medications. That's why there were no meds on the discharge summary." Interview with the Facility Transporter on 1/11/23 at 10:40 AM, revealed that the Maintenance Assistant went with him to transfer Resident #1 to his RR's home in Bryam, MS which is located	F 660			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/21/2023
NAME OF PROVIDER OR SUPPLIER RULEVILLE NURSING AND REHABILITATION CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 800 STANSEL DR RULEVILLE, MS 38771		
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F 660	Continued From page 45 approximately 2 to 2 1/2 hours from the nursing facility on 12/29/22 in the facility van. He stated "We didn't take any paperwork. Resident #1 had a bag of meds with him." He stated after arriving at the RR's home "a female talked through the Ring camera. She said a name, but I never understood it. No, he didn't go inside. He sat on the porch in front of the camera. The nursing home Administrator gave me the address of where to take him. I did call the facility saying there was no one coming to the door. I told the facility staff that someone was talking to me through the door Ring camera." He was unable to recall who he spoke to at the nursing home when he called to inform the facility that no one was coming to the door. Interview with the Maintenance Assistant on 1/11/23 at 10:55 AM, revealed he was with the Facility Transporter transferring Resident #1 to his RR's home. He stated "the Facility Transporter was talking to someone through the Ring doorbell. Yes, there was a zip-lock bag with medications. They were his meds from the nursing home. Yes, I saw pills. The person speaking on the Ring camera said his sister was not there." He stated that Resident #1 was wearing a shirt, pants, shoes, socks, jacket, and hat. He stated that Resident #1 "was sitting in a chair on the front porch in front of the door when we left. His belongings were beside him." The SA conducted an interview with the RR of Resident #1 on 1/12/23 at 8:31 AM, revealed that she was not home when the nursing home van dropped Resident #1 off at her house. She stated she was out of state at the time. She stated, "I had to call 911 and the police and ambulance had to come. There was no one	F 660			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/16/2023
FORM APPROVED
OMB NO. 0938-0391

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F 660	Continued From page 46 home when they left him. The house was locked. I had not been contacted by the nursing home prior to him coming home." She did state that there had been a family conference "24 days earlier" and discharge of Resident #1 was discussed. She stated, the administrator said 'well, he's got to go". She said Resident #1 does have behaviors if "provoked". She revealed that the police contacted an ambulance service and Resident #1 was admitted to the hospital and remains there at this time. She stated it took the police 2 hours to get to her residence to make initial contact with Resident #1. Interview with the facility Housekeeping Supervisor on 1/12/23 at 1:55 PM, revealed he was in the BOM's office on 12/29/22 when Resident #1 said he wanted to go home. He stated "he was agitated, saying he wanted to go home. (Name of BOM) tried to call the (RR) with no answer a couple of times. They offered to take him to his room. The Administrator said for him to let her read a paper to him about leaving AMA. He signed it, said he understood it. He left in the facility van to go home. In an interview with Licensed Practical Nurse (LPN) #2 on 1/12/23 at 3:18 PM, revealed that she contacted the Medical Director/Resident #1's primary physician to let him know that Resident #1 wanted to go home. "I called (name of Medical Director/Primary Physician) and let him know Resident #1 wanted to go home to his sister's home and needed an order for Home Health and the discharge. He said Ok. Resident #1 had already left when I called (name of Medical Director/Primary Physician). Interview with the Medical Director and Primary	F 660			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 660	Continued From page 47 Physician at 1:20 PM on 1/12/23, revealed that he was unaware the facility van left Resident #1 on his RR's front steps without anyone at home. Interview with the Administrator on 1/13/23 at 12:10 PM, revealed "We never sent a 30 day discharge letter related to Resident #1. We discussed it after a meeting with his RR/sister but decided against it. We wanted to wait on that." Removal Plan: Failure Statement: Facility failed to ensure residents were protected from physical abuse when Resident #1, who had a pattern and history of aggression, assaulted Resident #2 and #8 causing injury. The facility failed to ensure Resident #1 was transferred/discharged in a safe orderly manner with sufficient instruction related to medications. Facility failed to ensure Resident #1 Responsible Representative was notified of detailed discharge planning, and arrangements for post-discharge care including medication instruction. Summary: On 09/08/2022 Resident #1 began having episodes of aggression. Resident #1 was involved in a physical altercation with resident #8 who was the aggressor. Resident #8 sustained a laceration to the right eyebrow. Resident #1 was transferred to Geri-psych #1 and Resident #8 was transferred to Geri-psych #2. Resident #8 was assessed by Charge Nurse #3. First aide was provided by Charge Nurse #3 prior to transfer to Geri-psych #2. On 12/22/2022 Resident #1 was involved in an	F 660			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 660	Continued From page 48 altercation with Resident #2 resulting in injury to nose and face. Resident #1 and #2 were assessed by Director of Nursing and Charge Nurse #1 prior to sending to Hospital for evaluation. Resident #1 was returned to facility on 12/23/22 and placed on one on one observation. Resident #2 was treated at hospital for nasal fracture and facial swelling and returned to facility on 12/22/2022 at 9:09 p.m. Resident #1 remained on one on one observation at facility until discharged to Geri-psych #1 on 12/26/2022 for evaluation and treatment. He returned to facility on 12/29/2022 at which time he refused to be readmitted to facility and signed himself out Against Medical Advice. Facility transported resident to sisters home at his request on 12/29/2022 at 1:30 p.m. by facility transporters in the facility van with two attendants. Resident #1 was left unattended. Resident #1 had a zip lock bag with medication on his person when returned from Geri-Psych #1. Resident #1 medications were not reconciled by facility due to resident #1 refusal to readmit to facility. Medical Director was notified of Resident #1 leaving facility Against Medical Advice on 12/29/2022 at 2:36p.m. by Staff Development Coordinator. Ombudsman notified of Resident #1 leaving facility Against Medical Advice on 12/29/2022 at 5:52 p.m. by Administrator. Facility's action: 1.Abuse and neglect in-service for all staff completed by Staff Development Coordinator in-servicing starting on 12/22/22 through 12/25/22. The staff verbalized understanding the importance of protecting all residents from abuse to include resident to resident abuse and how to deal with combative residents. No staff will be	F 660			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 660	Continued From page 49 allowed to work until completion of in-service. 2. Licensed nurses, and Social Services in-serviced on safe and orderly discharge with sufficient instruction related to medications will be completed by 01/17/23 by Staff Development, Director of Nursing and Administrator. Social Services or licensed nursing staff will not be allowed to work until in-serviced. On 01/12/2023 through 1/14/2023 an Staff Development Nurse in-serviced Minimum Data Set Nurse, Social Services, and Nursing Service on baseline care plan policy. 3. Resident #1 was placed on one on one observation starting 12/22/22 while in facility until transferred to Geri-psych hospital for evaluation 12/26/22. Then returned from Geri-psych #1 on 12/29/22 and Resident #1 left Against Medical Advice prior to readmission. 4. Head to toe assessment was completed on Resident #8 by Charge Nurse #3 on 09/08/2022. Head to toe assessments of Residents #1 and #2 was completed by Charge Nurse #1 and Director of Nursing on 12/22/22. On 09/08/22, Resident #8 received in-house treatment of injury to right eyebrow and was later transferred to Geri-psych #2 for psych evaluation on 09/08/22 at 7:11 a.m. Residents #1 and #2 were sent to hospital for evaluation and treatment 12/22/22. 5. All residents were assessed for post traumatic issues related to abuse or neglect by Social Services, this was completed on 12/23/2022. No other residents were identified. 6. On 1/17/23, Staff Development Coordinator,	F 660			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 660	Continued From page 50 Director of Nursing, and Administrator in-serviced Licensed nurses to ensure sufficient instruction will be given to resident or their representative related to discharge medications. 7. Administrator and Director of Nursing in-serviced on safe and orderly discharge with medications and not to leave any residents unattended or unsupervised when transferring a resident by Regional Vice President on 01/13/2023. 8. Social Services and facility van transporters in-serviced on safe and orderly discharge with medications and not to leave any residents unattended or unsupervised when transferring a resident. Staff Development Coordinator completed an in-service 1/17/23 by 5 p.m. Social Service or van drivers will not be allowed to transport or transfer any resident until in-service is completed. 9. Disciplinary counseling completed on Administrator for failure to ensure Resident Representative was notified of discharge of Resident #1. Failure to ensure safe discharge of Resident #1 with medication reconciliation. Completed by Regional Vice President on 01/13/2023. 10. All residents discharged home was audited from July 15, 2022 through 12/29/2022 to ensure safe discharge with medication and care instruction. Only 1 resident was discharged home during this time frame, there were no issues noted. This audit was completed by Director of Nursing on 01/13/2023. Quality Assurance:	F 660			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 660	Continued From page 51 1. An emergency Quality Assurance Performance Improvement Committee meeting was held on 12/22/2022 at 9:30 a.m. until 10:30 a.m. to review the resident to resident abuse between Resident #1 and #2. In attendance was Administrator, Director of Nursing, Minimum Data Set Nurse, RN Unit Manager, Medical Records, Infection Control Nurse, House Keeping Supervisor, Social Service Director, Maintenance Director, Business Office Manager, Staff Development Nurse, and Medical Director. There were no new recommendations or changes made to policies. Abuse in-service completed for all staff, and Resident to Resident Abuse Audit Tool initiated. 2. Facility held a second emergency Quality Assurance Performance Improvement Committee meeting on 01/17/2023 4:00p.m. to review immediate jeopardy F-tag .600, F623, F660. In attendance was Administrator, Director of Nursing, Minimum Data Set Nurse, Medical Records, Infection Control Nurse, House Keeping Supervisor, Social Service Director, Maintenance Director, Business Office Manager, Staff Development Nurse, and Medical Director. Reviewed discharge look back from 07/15/2022 through 12/29/22 audit was performed Director of Nursing. One issues noted. There were no new recommendations or changes made to policies. Abuse in-service completed for all staff, and Resident to Resident Abuse Audit Tool initiated. 3. Facility held a third emergency Quality Assurance Performance Improvement Committee was held on 01/18/2023 at 3:30 p.m. to review immediate jeopardy F-tag 835. In attendance was Administrator, Director of Nursing, Minimum	F 660			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 660	Continued From page 52 Data Set Nurse, Medical Records, Infection Control Nurse, House Keeping Supervisor, Social Service Director, Maintenance Director, Business Office Manager, Staff Development Nurse, and Medical Director. Reviewed Safe Discharge policies and medications. No issues or concerns voiced. There were no new recommendations. The facility alleges compliance as reported to the Department of Health on 1/19/2023. VALIDATION: - Record review and staff interviews on 1/21/23 confirmed the facility had conducted Abuse and neglect in-service for all staff completed by Staff Development Coordinator in-servicing starting on 12/22/22 through 12/25/22. During staff interviews on 1/21/23, staff verbalized understanding the importance of protecting all residents from abuse to include resident to resident abuse and how to deal with combative residents. No staff will be allowed to work until completion of in-service. - Record review and staff interviews on 1/21/23 confirmed that Licensed nurses, and Social Services were in-serviced on safe and orderly discharge with sufficient instruction related to medications completed by 01/17/23 by Staff Development, Director of Nursing and Administrator. Social Services or licensed nursing staff will not be allowed to work until in-serviced. On 01/12/2023 through 1/14/2023 an Staff Development Nurse in-serviced Minimum Data Set Nurse, Social Services, and Nursing Service on baseline care plan policy.	F 660			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 660	Continued From page 53 3. Record review and interview on 1/21/23 confirmed that Resident #1 was placed on one on one observation starting 12/22/22 while in facility until transferred to Geri-psych hospital for evaluation 12/26/22. Then returned from Geri-psych #1 on 12/29/22 and Resident #1 left Against Medical Advice prior to readmission. 4. Record review and staff interview on 1/21/23 confirmed that a Head to toe assessment was completed on Resident #8 by Charge Nurse #3 on 09/08/2022. Head to toe assessments of Residents #1 and #2 was completed by Charge Nurse #1 and Director of Nursing on 12/22/22 . On 09/08/22, Resident #8 received in-house treatment of injury to right eyebrow and was later transferred to Geri-psych #2 for psych evaluation on 09/08/22 at 7:11 a.m. Residents #1 and #2 were sent to hospital for evaluation and treatment 12/22/22. 5. Record review and staff interviews on 1/21/23 confirmed that all residents were assessed for post traumatic issues related to abuse or neglect by Social Services, this was completed on 12/23/2022. No other residents were identified. 6. Staff interviews and record review on 1/21/23 confirmed that on 1/17/23, Staff Development Coordinator, Director of Nursing, and Administrator in-serviced Licensed nurses to ensure sufficient instruction will be given to resident or their representative related to discharge medications. 7. Record review and staff interviews on 1/21/23 confirmed that the Administrator and Director of	F 660			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 660	Continued From page 54 Nursing in-serviced on safe and orderly discharge with medications and not to leave any residents unattended or unsupervised when transferring a resident by Regional Vice President on 01/13/2023. 8. Staff interview and record review on 1/21/23 confirmed that Social Services and facility van transporters were in-serviced on safe and orderly discharge with medications and not to leave any residents unattended or unsupervised when transferring a resident. Staff Development Coordinator completed an in-service 1/17/23 by 5 p.m. Social Service or van drivers will not be allowed to transport or transfer any resident until in-service is completed. 9. Staff interview and record review on 1/21/23 confirmed that Disciplinary counseling completed on Administrator for failure to ensure Resident Representative was notified of discharge of Resident #1. Failure to ensure safe discharge of Resident #1 with medication reconciliation. Completed by Regional Vice President on 01/13/2023. 10. Record review and staff interviews on 1/21/23 confirmed that all residents discharged home was audited from July 15, 2022 through 12/29/2022 to ensure safe discharge with medication and care instruction. Only 1 resident was discharged home during this time frame, there were no issues noted. This audit was completed by Director of Nursing on 01/13/2023. Record review and staff interviews on 1/21/23 confirmed that an emergency Quality Assurance Performance Improvement Committee meeting was held on 12/22/2022 at 9:30 a.m. until 10:30	F 660			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 660	Continued From page 55 a.m. to review the resident to resident abuse between Resident #1 and #2. In attendance was Administrator, Director of Nursing, Minimum Data Set Nurse, RN Unit Manager, Medical Records, Infection Control Nurse, House Keeping Supervisor, Social Service Director, Maintenance Director, Business Office Manager, Staff Development Nurse, and Medical Director. There were no new recommendations or changes made to policies. Abuse in-service completed for all staff, and Resident to Resident Abuse Audit Tool initiated. Staff interviews and record review on 1/21/23 confirmed that the facility held a second emergency Quality Assurance Performance Improvement Committee meeting on 01/17/2023 4:00p.m. to review immediate jeopardy F-tag .600, F623, F660. In attendance was Administrator, Director of Nursing, Minimum Data Set Nurse, Medical Records, Infection Control Nurse, House Keeping Supervisor, Social Service Director, Maintenance Director, Business Office Manager, Staff Development Nurse, and Medical Director. Reviewed discharge look back from 07/15/2022 through 12/29/22 audit was performed Director of Nursing. One issues noted. There were no new recommendations or changes made to policies. Abuse in-service completed for all staff, and Resident to Resident Abuse Audit Tool initiated. Record review and staff interviews on 1/21/23 confirmed that the facility held a third emergency Quality Assurance Performance Improvement Committee was held on 01/18/2023 at 3:30 p.m. to review immediate jeopardy F-tag 835. In attendance was Administrator, Director of Nursing, Minimum Data Set Nurse, Medical	F 660			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 660	Continued From page 56 Records, Infection Control Nurse, House Keeping Supervisor, Social Service Director, Maintenance Director, Business Office Manager, Staff Development Nurse, and Medical Director. Reviewed Safe Discharge policies and medications. No issues or concerns voiced. There were no new recommendations. Staff interviewed on 1/21/23 were seven (7) Certified Nurse Aides (CNA), two (2) Registered Nurses (RN), three (3) Licensed Practical Nurses (LPN), one (1) Business Office Manager (BOM), 1 Social Worker (SW), 1 Minimum Data Set LPN, 1 Administrator, 1 Director of Nurses, 2 Covid Screeners.	F 660			
F 835 SS=J	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, facility policy/procedure review, and job description review the facility failed to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident as evidenced by Resident #1 was discharged 12/29/22 without the Resident Representative (RR) being notified and Resident #1 was left alone outside the RR's locked home with a bag of medications with no discharge instructions for	F 835	1. Resident #1 was discharged to Resident's Representative's home on 12/29/2022. Resident #1 was transported by facility staff and left unsupervised with medications on 12/29/2022. Resident #1 is no longer a resident at this facility. 2. All residents have the potential to be affected by this deficient practice. 3. On 01/23/2023 Staff Development	2/19/23	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER RULEVILLE NURSING AND REHABILITATION CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 800 STANSEL DR RULEVILLE, MS 38771		
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F 835	Continued From page 57 the medication for one (1) of five (5) discharged residents sampled. The facility's failure to notify Resident #1's (RR) at the time of the discharge and leaving Resident #1 outside the home alone placed Resident #1 in a situation that would likely cause serious injury, harm, impairment, or death. The SA identified an Immediate Jeopardy (IJ) that began on 12/29/22 when the facility failed to ensure a safe discharge for Resident #1. Two (2) staff members transported Resident #1 to his RR's home per the facility van. The staff members did not see a person at the home. Both staff members stated that Resident #1 had medications in a bag. There was a Ring doorbell system and a female voice said to facility staff that no one was at home. The facility staff left Resident #1 sitting in a chair on the front porch of the RR's home. On 1/18/23 at 1:00 PM, the SA notified the Administrator, Director of Nurses (DON) and Regional Vice President of the IJ and provided the facility with the IJ template. The IJ existed at: CFR 483.70 Administration (F835) -Scope and Severity "J". The facility submitted an acceptable Removal Plan on 1/19/23, in which the facility alleged all corrective action to remove the IJ were completed on 1/19/23 and IJ removed on 1/19/23. The SA validated the Removal Plan on 1/21/23, and determined the IJ was removed on 1/19/23,	F 835	Coordinator and Director of Nursing in-serviced licensed nurses and Social Services regarding safe and orderly discharge with sufficient instructions related to medications. This in-service was completed on 01/23/2023. No licensed nurses or Social Worker will be allowed to work until in-serviced. On 01/25/2023 the Director of Nursing and the Staff Development Coordinator in-serviced the facility staff on resident to resident altercations, abuse and neglect, and how to deal with residents with combative behavior. On 01/13/2023 the Vice-President in-serviced the Administrator and the Director of Nursing regarding safe and orderly discharge with sufficient instructions related to medications. 4. Starting on 01/26/2023 the Director of Nursing initiated the van driver audit to ensure residents are transported safely with medications and residents are not left unsupervised. This audit will be conducted (5) five times a week for (4) four weeks then weekly for (4) four weeks. The Director of Nursing will forward the results of all audits to the Executive Director beginning on 01/26/2023. Starting on 01/27/2023 the Executive Director initiated monitoring for completeness and accuracy of van driver transport audit(4) four weeks then monthly times (1) one month. The Executive Director will forward the results of the monitoring to the Quality Assurance Committee meeting monthly times (2) two months starting on		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/16/2023
FORM APPROVED
OMB NO. 0938-0391

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F 835	Continued From page 58 prior to exit. Therefore, the scope and severity for CFR 483.70 Administration (F835), was lowered from a "J" to a "D", while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Cross reference F623. Record review of the facility's Executive Director/Administrator Job Description for "Job Title: Executive Director. Department: Administration" effective 8/01/2012 revealed "The Executive Director leads and directs the overall operation of the facility in accordance with resident needs, government regulations and Facility policies so as to maintain quality care for the residents while achieving of the Facility's business objectives." The job description revealed "Standard Requirements 2. Is knowledgeable of resident rights and supports an atmosphere which allows for the privacy, dignity and well-being of all residents in a safe, secure environment." Record review of the facility's "Discharge and transfer policies-Involuntary" policy/procedure, last revised "7/18" revealed the "Responsibility: All staff, monitored by the Director of Nursing and Executive Director." The "Procedure: 4. The facility will provide sufficient orientation to residents to ensure safe and orderly transfer or discharge from the facility..." Record review of the Policy/procedure of the	F 835	02/08/2023. The Quality Assurance Committee will review for any recommendations as deemed necessary. The results of the audits and monitoring will be maintained in the Executive Director's office.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/16/2023
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OMB NO. 0938-0391

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F 835	Continued From page 59 facility's "Discharge Medications" last revised "8/16" revealed the policy "Discharge Medications Policy: Medications are sent with the resident upon discharge only under conditions that protect the resident and ensure compliance with the law." Record review of the Face Sheet revealed Resident # 1 was readmitted to the facility on 9/1/22. His admitting diagnosis included Schizophrenia, Bipolar Disorder, Other Seizures, Hypothyroidism. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) was 10/4/22 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #1 was cognitively intact. Record review of the medical record for Resident #1 had returned to the facility on 12/29/22 from a Geri-psych unit admission on 12/26/22. He was discharged from the Geri-psych unit on 12/29/22 due to refusal to take medications and participate in his treatment. He arrived at the nursing home and refused to go to his room. He was requesting to discharge from the nursing home and go to his RR's home in Byram, Ms. The facility attempted three (3) times to contact the RR with no success. Resident #1 was transported in the nursing homes van by 2 staff members to the RR's home and left outside the home, unattended. Interview with the Administrator on 1/11/23 at 11:44 AM, revealed that Resident #1 was sent to the Geri-psych for evaluation and treatment on 12/26/22. The Administrator stated "We sent him with his medications to senior care. He returned with his same medications. I saw the meds with	F 835			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/16/2023
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OMB NO. 0938-0391

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F 835	Continued From page 60 him when he returned here. The facility did not send him home with any medications. That's why there were no meds on the discharge summary." Interview with the Facility Transporter on 1/11/23 at 10:40 AM, revealed that the Maintenance Assistant went with him to transfer Resident #1 to his RR's home in Bryam, MS, which is located approximately 2 to 2 1/2 hours from the nursing facility, on 12/29/22 in the facility van. He stated "We didn ' t take any paperwork. Resident #1 had a bag of meds with him." He stated after arriving at the RR's home "a female talked through the Ring camera. She said a name, but I never understood it. No, he didn ' t go inside. He sat on the porch in front of the camera. The nursing home Administrator gave me the address of where to take him. I did call the facility saying there was no one coming to the door. I told the facility staff that someone was talking to me through the door Ring camera." He was unable to recall who he spoke to at the nursing home when he called to inform the facility that no one was coming to the door. Interview with the Maintenance Assistant on 1/11/23 at 10:55 AM, revealed he was with the Facility Transporter transferring Resident #1 to his RR's home. He stated "the Facility Transporter was talking to someone through the Ring doorbell. Yes, there was a zip-lock bag with medications. They were his meds from the nursing home. Yes, I saw pills. The person speaking on the Ring camera said his sister was not there." He stated that Resident #1 was wearing a shirt, pants, shoes, socks, jacket, and hat. He stated that Resident #1 "was sitting in a chair on the front porch in front of the door when we left. His belongings were beside him."	F 835			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 835	Continued From page 61 The SA conducted an interview with the RR of Resident #1 on 1/12/23 at 8:31 AM, revealed that she was not home when the nursing home van dropped Resident #1 off at her house. She stated she was out of state at the time. She stated, "I had to call 911 and the police and ambulance had to come. There was no one home when they left him. The house was locked. I had not been contacted by the nursing home prior to him coming home." She did state that there had been a family conference "24 days earlier" and discharge of Resident #1 was discussed. She stated, the Administrator said "well, he's got to go". She said Resident #1 does have behaviors if "provoked". She revealed that the police contacted an ambulance service and Resident #1 was admitted to the hospital and remains there at this time. She stated it took the police 2 hours to get to her residence to make initial contact with Resident #1. Interview with the Administrator on 1/13/23 at 12:10 PM, revealed "We never sent a 30-day discharge letter," related to Resident #1. "We discussed it after a meeting with his RR/sister but decided against it. We wanted to wait on that." Interview with the facility Housekeeping Supervisor on 1/12/23 at 1:55 PM, revealed he was in the BOM's office on 12/29/22 when Resident #1 said he wanted to go home. He stated "he was agitated, saying he wanted to go home. (Name of BOM) tried to call the (RR) with no answer a couple of times. He left in the facility van to go home. Interview with Licensed Practical Nurse (LPN) #2 on 1/12/23 at 3:18 PM, revealed that she	F 835			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 835	Continued From page 62 contacted the Medical Director/Resident #1 's primary physician to let him know that Resident #1 wanted to go home. "I called (name of Medical Director/Primary Physician) and let him know Resident #1 wanted to go home to his sister's home and needed an order for Home Health and the discharge. He said "OK". Resident #1 had already left when I called (Name of Medical Director/Primary Physician). Interview with the Medical Director and Primary Physician at 1:20 PM on 1/12/23, revealed that he was unaware the facility van left Resident #1 on his RR's front steps without anyone at home. Removal Plan: Failure Statement: Facility failed to ensure residents were protected from physical abuse when Resident #1, who had a pattern and history of aggression, assaulted Resident #2 and #8 causing injury. The facility failed to ensure Resident #1 was transferred/discharged in a safe orderly manner with sufficient instruction related to medications. Facility failed to ensure Resident #1 Responsible Representative was notified of detailed discharge planning, and arrangements for post-discharge care including medication instruction. Summary: On 09/08/2022 Resident #1 began having episodes of aggression. Resident #1 was involved in a physical altercation with resident #8 who was the aggressor. Resident #8 sustained a laceration to the right eyebrow. Resident #1 was transferred to Geri-psych #1 and Resident #8 was	F 835			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 835	Continued From page 63 transferred to Geri-psych #2. Resident #8 was assessed by Charge Nurse #3. First aide was provided by Charge Nurse #3 prior to transfer to Geri-psych #2. On 12/22/2022 Resident #1 was involved in an altercation with Resident #2 resulting in injury to nose and face. Residents #1 and #2 were assessed by Director of Nursing and Charge Nurse #1 prior to sending to Hospital for evaluation. Resident #1 was returned to facility on 12/23/22 and placed on one-on-one observation. Resident #2 was treated at hospital for nasal fracture and facial swelling and returned to facility on 12/22/2022 at 9:09 p.m. Resident #1 remained on one-on-one observation at facility until discharged to Geri-psych #1 on 12/26/2022 for evaluation and treatment. He returned to facility on 12/29/2022 at which time he refused to be readmitted to facility and signed himself out Against Medical Advice. Facility transported resident to sisters ' home at his request on 12/29/2022 at 1:30 p.m. by facility transporters in the facility van with two attendants. Resident #1 was left unattended. Resident #1 had a zip lock bag with medication on his person when returned from Geri-Psych #1. Resident #1 medications were not reconciled by facility due to resident #1 refusal to readmit to facility. Medical Director was notified of Resident #1 leaving facility Against Medical Advice on 12/29/2022 at 2:36p.m. by Staff Development Coordinator. Ombudsman notified of Resident #1 leaving facility Against Medical Advice on 12/29/2022 at 5:52 p.m. by Administrator. Facility's action:	F 835			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 835	Continued From page 64 1. Abuse and neglect in-service for all staff completed by Staff Development Coordinator in-servicing starting on 12/22/22 through 12/25/22. The staff verbalized understanding the importance of protecting all residents from abuse to include resident to resident abuse and how to deal with combative residents. No staff will be allowed to work until completion of in-service. 2. Licensed nurses, and Social Services in-serviced on safe and orderly discharge with sufficient instruction related to medications will be completed by 01/17/23 by Staff Development, Director of Nursing and Administrator. Social Services or licensed nursing staff will not be allowed to work until in-serviced. On 01/12/2023 through 1/14/2023 an Staff Development Nurse in-serviced Minimum Data Set Nurse, Social Services, and Nursing Service on baseline care plan policy. 3. Resident #1 was placed on one on one observation starting 12/22/22 while in facility until transferred to Geri-psych hospital for evaluation 12/26/22. Then returned from Geri-psych #1 on 12/29/22 and Resident #1 left Against Medical Advice prior to readmission. 4. Head to toe assessment was completed on Resident #8 by Charge Nurse #3 on 09/08/2022. Head to toe assessments of Residents #1 and #2 was completed by Charge Nurse #1 and Director of Nursing on 12/22/22. On 09/08/22, Resident #8 received in-house treatment of injury to right eyebrow and was later transferred to Geri-psych #2 for psych evaluation on 09/08/22 at 7:11 a.m. Residents #1 and #2 were sent to hospital for evaluation and treatment	F 835			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 835	Continued From page 65 12/22/22. 5. All residents were assessed for post traumatic issues related to abuse or neglect by Social Services, this was completed on 12/23/2022. No other residents were identified. 6. On 1/17/23, Staff Development Coordinator, Director of Nursing, and Administrator in-serviced Licensed nurses to ensure sufficient instruction will be given to resident or their representative related to discharge medications. 7. Administrator and Director of Nursing in-serviced on safe and orderly discharge with medications and not to leave any residents unattended or unsupervised when transferring a resident by Regional Vice President on 01/13/2023. 8. Social Services and facility van transporters in-serviced on safe and orderly discharge with medications and not to leave any residents unattended or unsupervised when transferring a resident. Staff Development Coordinator completed an in-service 1/17/23 by 5 p.m. Social Service or van drivers will not be allowed to transport or transfer any resident until in-service is completed. 9. Disciplinary counseling completed on Administrator for failure to ensure Resident Representative was notified of discharge of Resident #1. Failure to ensure safe discharge of Resident #1 with medication reconciliation. Completed by Regional Vice President on 01/13/2023. 10. All residents discharged home was audited	F 835			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 835	Continued From page 66 from July 15, 2022 through 12/29/2022 to ensure safe discharge with medication and care instruction. Only 1 resident was discharged home during this time frame, there were no issues noted. This audit was completed by Director of Nursing on 01/13/2023. Quality Assurance: 1. An emergency Quality Assurance Performance Improvement Committee meeting was held on 12/22/2022 at 9:30 a.m. until 10:30 a.m. to review the resident to resident abuse between Resident #1 and #2. In attendance was Administrator, Director of Nursing, Minimum Data Set Nurse, RN Unit Manager, Medical Records, Infection Control Nurse, House Keeping Supervisor, Social Service Director, Maintenance Director, Business Office Manager, Staff Development Nurse, and Medical Director. There were no new recommendations or changes made to policies. Abuse in-service completed for all staff, and Resident to Resident Abuse Audit Tool initiated. 2. Facility held a second emergency Quality Assurance Performance Improvement Committee meeting on 01/17/2023 4:00p.m. to review immediate jeopardy F-tag .600, F623, F660. In attendance was Administrator, Director of Nursing, Minimum Data Set Nurse, Medical Records, Infection Control Nurse, House Keeping Supervisor, Social Service Director, Maintenance Director, Business Office Manager, Staff Development Nurse, and Medical Director. Reviewed discharge look back from 07/15/2022 through 12/29/22 audit was performed Director of Nursing. One issue noted. There were no new recommendations or changes made to policies. Abuse in-service completed for all staff, and	F 835			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 835	Continued From page 67 Resident to Resident Abuse Audit Tool initiated. 3. Facility held a third emergency Quality Assurance Performance Improvement Committee was held on 01/18/2023 at 3:30 p.m. to review immediate jeopardy F-tag 835. In attendance was Administrator, Director of Nursing, Minimum Data Set Nurse, Medical Records, Infection Control Nurse, House Keeping Supervisor, Social Service Director, Maintenance Director, Business Office Manager, Staff Development Nurse, and Medical Director. Reviewed Safe Discharge policies and medications. No issues or concerns voiced. There were no new recommendations. The facility alleges compliance as reported to the Department of Health on 1/19/2023. VALIDATION: 1. Record review and staff interviews on 1/21/23 confirmed the facility had conducted Abuse and neglect in-service for all staff completed by Staff Development Coordinator in-servicing starting on 12/22/22 through 12/25/22. During staff interviews on 1/21/23, staff verbalized understanding the importance of protecting all residents from abuse to include resident to resident abuse and how to deal with combative residents. No staff will be allowed to work until completion of in-service. 2. Record review and staff interviews on 1/21/23 confirmed that Licensed nurses, and Social Services were in-serviced on safe and orderly discharge with sufficient instruction related to medications completed by 01/17/23 by Staff Development, Director of Nursing and Administrator. Social Services or licensed nursing	F 835			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 835	Continued From page 68 staff will not be allowed to work until in-serviced. On 01/12/2023 through 1/14/2023 an Staff Development Nurse in-serviced Minimum Data Set Nurse, Social Services, and Nursing Service on baseline care plan policy. 3. Record review and interview on 1/21/23 confirmed that Resident #1 was placed on one-on-one observation starting 12/22/22 while in facility until transferred to Geri-psych hospital for evaluation 12/26/22. Then returned from Geri-psych #1 on 12/29/22 and Resident #1 left Against Medical Advice prior to readmission. 4. Record review and staff interview on 1/21/23 confirmed that a Head-to-toe assessment was completed on Resident #8 by Charge Nurse #3 on 09/08/2022. Head to toe assessments of Residents #1 and #2 was completed by Charge Nurse #1 and Director of Nursing on 12/22/22. On 09/08/22, Resident #8 received in-house treatment of injury to right eyebrow and was later transferred to Geri-psych #2 for psych evaluation on 09/08/22 at 7:11 a.m. Residents #1 and #2 were sent to hospital for evaluation and treatment 12/22/22. 5. Record review and staff interviews on 1/21/23 confirmed that all residents were assessed for post traumatic issues related to abuse or neglect by Social Services, this was completed on 12/23/2022. No other residents were identified. 6. Staff interviews and record review on 1/21/23 confirmed that on 1/17/23, Staff Development Coordinator, Director of Nursing, and Administrator in-serviced Licensed nurses to ensure sufficient instruction will be given to resident or their representative related to	F 835			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/21/2023
NAME OF PROVIDER OR SUPPLIER RULEVILLE NURSING AND REHABILITATION CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 800 STANSEL DR RULEVILLE, MS 38771		
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F 835	Continued From page 69 discharge medications. 7. Record review and staff interviews on 1/21/23 confirmed that the Administrator and Director of Nursing in-serviced on safe and orderly discharge with medications and not to leave any residents unattended or unsupervised when transferring a resident by Regional Vice President on 01/13/2023. 8. Staff interview and record review on 1/21/23 confirmed that Social Services and facility van transporters were in-serviced on safe and orderly discharge with medications and not to leave any residents unattended or unsupervised when transferring a resident. Staff Development Coordinator completed an in-service 1/17/23 by 5 p.m. Social Service or van drivers will not be allowed to transport or transfer any resident until in-service is completed. 9. Staff interview and record review on 1/21/23 confirmed that Disciplinary counseling completed on Administrator for failure to ensure Resident Representative was notified of discharge of Resident #1. Failure to ensure safe discharge of Resident #1 with medication reconciliation. Completed by Regional Vice President on 01/13/2023. 10. Record review and staff interviews on 1/21/23 confirmed that all residents discharged home was audited from July 15, 2022 through 12/29/2022 to ensure safe discharge with Interview with Licensed Practical Nurse (LPN) #2 on 1/12/23 at 3:18 PM, revealed that she contacted the Medical Director/Resident #1 's primary physician to let him know that Resident #1 wanted to go home. "I called (name of Medical Director/Primary	F 835			

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F 835	Continued From page 70 Physician) and let him know Resident #1 wanted to go home to his sister 's home and needed an order for Home Health and the discharge. He said Ok. Resident #1 had already left when I called (name of Medical Director/Primary Physician). medication and care instruction. Only 1 resident was discharged home during this time frame, there were no issues noted. This audit was completed by Director of Nursing on 01/13/2023. Record review and staff interviews on 1/21/23 confirmed that an emergency Quality Assurance Performance Improvement Committee meeting was held on 12/22/2022 at 9:30 a.m. until 10:30 a.m. to review the resident-to-resident abuse between Resident #1 and #2. In attendance was Administrator, Director of Nursing, Minimum Data Set Nurse, RN Unit Manager, Medical Records, Infection Control Nurse, House Keeping Supervisor, Social Service Director, Maintenance Director, Business Office Manager, Staff Development Nurse, and Medical Director. There were no new recommendations or changes made to policies. Abuse in-service completed for all staff, and Resident to Resident Abuse Audit Tool initiated. Staff interviews and record review on 1/21/23 confirmed that the facility held a second emergency Quality Assurance Performance Improvement Committee meeting on 01/17/2023 4:00p.m. to review immediate jeopardy F-tag .600, F623, F660. In attendance was Administrator, Director of Nursing, Minimum Data Set Nurse, Medical Records, Infection Control Nurse, House Keeping Supervisor, Social Service	F 835			

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F 835	Continued From page 71 Director, Maintenance Director, Business Office Manager, Staff Development Nurse, and Medical Director. Reviewed discharge look back from 07/15/2022 through 12/29/22 audit was performed Director of Nursing. One issue noted. There were no new recommendations or changes made to policies. Abuse in-service completed for all staff, and Resident to Resident Abuse Audit Tool initiated. Record review and staff interviews on 1/21/23 confirmed that the facility held a third emergency Quality Assurance Performance Improvement Committee was held on 01/18/2023 at 3:30 p.m. to review immediate jeopardy F-tag 835. In attendance was Administrator, Director of Nursing, Minimum Data Set Nurse, Medical Records, Infection Control Nurse, House Keeping Supervisor, Social Service Director, Maintenance Director, Business Office Manager, Staff Development Nurse, and Medical Director. Reviewed Safe Discharge policies and medications. No issues or concerns voiced. There were no new recommendations. Staff interviewed on 1/21/23 were seven (7) Certified Nurse Aides (CNA), two (2) Registered Nurses (RN), three (3) Licensed Practical Nurses (LPN), one (1) Business Office Manager (BOM), 1 Social Worker (SW), 1 Minimum Data Set LPN, 1 Administrator, 1 Director of Nurses, 2 Covid Screeners.	F 835			