MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	67RH	A. BUILDING: _____ B. WING _____	C 06/14/2023

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

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M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI) # MS #21622 from 6/13/23 to 6/14/23 for not properly using vehicle safety restraints and not properly monitoring a resident during a transport for Resident #1. During the survey the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm and cited M640. The facility is licensed for 111 of beds and at the time of the survey the census was 104.	M 000		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level II Based on staff interviews, record review, and facility policy review, the facility failed to promote safety, during a transport of a resident, by not using a vehicle safety lap restraint on a resident, failed to provide proper monitoring of a resident during a transport, and failed to avoid an accident for a resident that fell out of a motorized wheelchair during transport in the nursing facility van, for one (1) of five (5) residents reviewed for accidents. Resident #1. Findings include:	M 640	On 7/31/2022 Resident #1 was sent via ambulance to the emergency room to ensure that he had not sustained any injuries after a fall from his wheelchair during transportation on facility van. The emergency room noted that resident #1 had not been injured as a result of the fall on 7/31/2023. Certified Nursing Assistant #1 and Certified Nursing Assistant #2 are no longer employed at the facility. 2. Any resident that is transported in the facility van has the potential to be affected by the deficient practice.	7/25/23

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M 640	Continued From page 1 Review of the facility policy titled, "Resident Transportation Guidelines," with no date, revealed "Purpose: ... The appropriate use of passenger / occupant safety restraint systems are required. Any facility rules prohibiting or minimizing the use of restraints does not apply to the occupants of a moving vehicle. ... m. Prior to departure driver will check to ensure all passengers are properly seated with safety restraints appropriately applied ... Negative findings will be resolved prior to vehicle movement. ... l. The vehicle should not be moved from its parked position until all passengers are properly seated, safety restraints fully and appropriately applied ... D. Other staffing (Non-Driver) ... b. Support personnel will be trained on transportation related equipment and procedures. Procedure and equipment operation include but are not limited to wheelchair lift, loading and restraint system(s). ... d. Support personnel should be seated where they can best monitor and manage passenger needs and activities during the trip to promote passenger safety and comfort as well as minimize driver distractions." Record review of the "Resident Incident Report," dated and timed 7/13/22 06:21 PM, for Resident #1, revealed "Incident Type: Fall; Type of Injury: None; Location: Facility vehicle; Equipment: wheelchair - motorized; ... Incident Reported by: (CNA #1); Report Prepared by: (RN #1) ... 7/13/22 6:21 PM Received a phone call per Van Driver CNA, (CNA #1). She stated, "(RN #1) (Resident #1) just fell." I questioned her further and she said resident fell from his w/c (wheelchair) in the van and was c/o (complaining of) pain. I told her not to move the van, but to call the paramedics and send him to the VA hospital in Memphis for evaluation and treatment. No open areas Immediate Actions Taken: Resident	M 640	3. An annual driver assessment for competency and correct usage of the facility van safety restraints to promote safety during resident transportation, providing proper monitoring of a resident during a transport, and avoiding resident accident was initiated on 6/29/2023 by the Maintenance Director for all facility van drivers. The Maintenance Director provided education to all facility van drivers on appropriate use of passenger/occupant safety restraint systems on 6/29/2023. 4. Results of the audit/monitor will be reviewed by the Executive Director for entirety and accuracy weekly x 4 weeks then monthly x 1 month beginning 6/30/2023. Any concerns will be immediately addressed by the Maintenance Director beginning 6/23/2023. Facility Maintenance Director will use the annual driver assessment to audit/monitor the correct use of safety restraints during resident transfers starting 6/23/2023, four times a week on three residents per week times eight weeks, then one resident per week times one month. These audits/monitor will be keep in the Executive Director's office. Findings of the audits of safety restraints during resident transfers will be reviewed in Quality Assurance meeting monthly times three months beginning 7/14/2023.	

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transferred to ER at Memphis VA."

An interview on 6/13/23 at 11:44 AM, with Resident #1 revealed he was sitting in his motorized wheelchair traveling in the nursing facility transport van from the Memphis airport, when the Certified Nursing Assistant (CNA) made a hard right turn and he fell out of his motorized wheelchair onto his left side. He noted he hit his left shoulder and the left side of his head on the floor. He shared that the impact of the fall caused him to hurt his neck and back. Resident #1 revealed he already suffered from back and neck pain prior to the fall, but the fall made it worse. He revealed the CNA neglected to put the transport van's lap belt over him to secure him in his motorized wheelchair. He noted he did not refuse the transport van seat belt, did not ask to use the seat belt in his wheelchair, and did not tell anyone that his motorized wheelchair seat belt was broken. He shared that both CNAs were in the front seats of the van with their back to him.

A telephone interview on 6/13/23 at 03:09 PM, with the CNA #1 revealed she and CNA #2 transported Resident #1 from the Memphis Airport to the nursing facility on 7/13/22 and he was not buckled/secured in his motorized wheelchair. She revealed that Resident #1 was found in the airport arguing with staff about something being broken, by them, on his motorized wheelchair. She also revealed she asked Resident #1 what was damaged on his motorized wheelchair and that he yelled at her, telling her not to worry about it. CNA #1 provided information regarding putting Resident #1 in the nursing facility's lift van and attempted to buckle him and his wheelchair in properly before moving the vehicle. She noted when she attempted to place the lap seat belt over Resident #1 to secure

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him in the wheelchair, he refused to use the van lap seat belt, and told her he did not need it because he had a seat belt in his wheelchair. She revealed she did not apply the transport van's lap seat belt and did not check to see if Resident #1 was secured with his seat belt in the motorized wheelchair. She revealed she and CNA #2 sat in the front seats of the van and Resident #1 sat in the back of the van alone. She noted Resident #1 asked her to make a stop to allow him to buy himself a meal. She also noted she stopped at a stop light to wait for passing traffic, and when she made the turn, she heard CNA #2 say Resident #1 had fallen out of the motorized wheelchair. She revealed he was on the floor, laying on his side. She shared she did not see him fall, because she was driving. She then reported Resident #1 said his seatbelt was broken in the motorized wheelchair. She revealed she saw Resident #1's seat belt in the motorized wheelchair after his fall, it was unbuckled, and did not look like it was broken.

State Agency (SA) attempted a telephone interview on 6/13/23 at 03:15 PM with CNA #2, but the telephone number was incorrect. No other phone number was available.

An interview on 6/13/23 at 02:00 PM, with the Director of Nursing (DON) revealed she was not aware of Resident #1 having a broken seat belt or any requests for damage repairs for his motorized wheelchair. She confirmed CNA #1 should have completely assessed Resident #1 for safety related to being secured into his motorized wheelchair with a lap seat belt before moving the transport van.

An interview on 6/13/23 at 04:00 PM, with Registered Nurse (RN) #1, revealed she was

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made aware, by CNA #1, that Resident #1 had fallen out of his motorized wheelchair during transport, and that she had completed the Incident Report. She also revealed CNA #1 informed her Resident #1 was not buckled into his motorized wheelchair. She noted she was not aware of any damage to Resident #1's motorized wheelchair and no knowledge of a request for repairs.

An interview on 6/14/23 at 09:30 AM, with the Administrator confirmed CNA #1 did not ensure that Resident #1 was securely buckled into his motorized wheelchair before moving the transport van on 7/13/22. The Administrator confirmed the support staff, CNA #2, was not sitting in the back of the transport van, with Resident #1, to properly monitor him. She noted these actions placed Resident #1 at risk for a possible accident and CNA #1 and CNA #2 did not adhere to the facility policy for securing a resident with the proper vehicle safety restraints for a safe transport.

Record review of the CNA #2's witness statement dated 7/14/22, for Resident #1, revealed On yesterday 7/13/22 I was with CNA #1 to transport (Resident #1) back to the facility from the Memphis Airport. During the pickup and loading (Resident #1) onto the van he did not mentioned that his wheelchair seatbelt was broken during the process of (CNA #1) strapping his chair in the way she was trained to do so. While leaving the Airport he said, "he was hungry and mentioned what he wanted to eat. (CNA #1) proceeded to drive until she came to the light to make a complete stop. When it was her turn to turn at the light, (Resident #1) fell forward out of his chair without saying anything to warn us that he was falling until he fell. That's when I turned around and said, "(CNA #1) he fell out out his chair."

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(CNA #1) instantly parked the van, put her emergency lights on and we asked him was he okay. He said, "he was hurting." We unstrapped his chair from the from the floor, and he gave us directions on how to roll his chair backwards slowly, we asked him where was he hurting at and he said his back, legs and head. (CNA #1) and I slowly rolled him over to get him back up in his chair. Once we got him back in his chair (CNA #1) called (RN #1) to inform her of the accident and she told to called the ambulance"

Record review of the "EDUCATIONAL IN-SERVICE RECORD" dated 6/21/23, for CNA #1 and CNA #2, revealed "Title: Resident Transportation Guidelines: Subject: Transportation provided to residents to attend appointments and other events. The appropriate use of passenger/occupant safety restraint systems."

Record review of Departmental Notes for Resident #1 revealed :7/14/22 4:07 pm ... Late entry for 7/13/22 6:21 pm Received a phone call per Van Driver CNA, (CNA #1). She stated, "(RN #1), (Resident #1) just fell." I questioned her further and she said resident fell from his w/c in the van and was c/o pain. I told her not to move the van, but to call the paramedics and send him to the VA hospital in Memphis for evaluation and treatment. Then I called (the Administrator), ED and made her aware. ... 7/14/22 10:21 PM ... Received resident lying in bed alert and responsive respirations even and unlabored denies pain to distress."

Record review of the "Face Sheet" for Resident #1 revealed an admission date of 6/6/08 and diagnoses of Paraplegia, Unspecified, Disorder of Muscle, Unspecified, Pain, Unspecified, and

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M 640	Continued From page 6 Muscle Weakness (Generalized). Record review of the Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 6/5/2023, for Resident #1, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #1 is cognitively intact.	M 640		