

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

PRINTED: 01/06/2022
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 12/07/2021
NAME OF PROVIDER OR SUPPLIER RULEVILLE NURSING AND REHABILITATION CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 800 STANSEL DR RULEVILLE, MS 38771		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Compliant Investigation (CI) for CI #18231 and CI#18122 on 12/7/21. CI #18231 was filed by the family with allegations of Quality of Care and the RP was not notified with changes in condition. CI#18122 was reported by another medical facility with allegations of abuse. The complaints were unsubstantiated with one (1) deficiency cited F609 S/S-D for failure to report to licensure and certification for CI#18122. The facility is licensed for 120 beds with a census of 117 at time of survey.	F 000			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609			1/3/22

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

TITLE

(X6) DATE

Electronically Signed

12/29/2021

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 609	Continued From page 1 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, policy procedure review and interview; the facility failed to report to licensure and certification an allegation of abuse regarding Resident #1. This was based on one (1) of three (3) incidents/investigations reviewed. Findings include: Policy/procedure review of the facility's "Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Residents' Property" dated 7/2003 revealed "REPORTING: A. Any employee who suspects an alleged violation shall immediately notify the Executive Director or his/her designee. The Executive Director shall also notify the appropriate state agency in accordance with state law." Interview with the previous Executive Director on 12/7/21 at 1:15 PM revealed she recalled that the social worker from Geri-psych called stating that Resident #1 had made an allegation of sexual abuse. She said the Geri-psych social worker stated she was calling in the abuse allegation to Licensure and Certification so she didn't believe she needed to report it also. The facility sent Resident #1 to Geri-psych because she believed she was pregnant and during incontinent	F 609	1. Resident #1 was assessed on 12/07/21 by the Director of Nursing. Resident #1 had no ill effects from the facility's failure to notify state agencies within the required two(2)hour time frame. The allegation of sexual abuse was later denied by Resident #1 and indicated that she had not been abused or neglected while in the facility. 2. All Residents have the potential to be affected by this deficient practice. 3. The Executive Director at the facility at the time of this allegation is no longer employed. The Interim Executive Director completed an in-service on 12/07/21 provided by the Vice President of Operations. Reviewed in this in-service was the facility's Abuse Prevention policy and reporting requirements including a chart defining 2 hour versus 24 hour reporting requirements to the State Survey Agency as well as adult protective services in accordance with State Law through established procedures. On 12/7/21 an in-service was initiated for licensed nurses and department managers by staff development and/or the Director of Nursing on ensuring that alleged violations involving abuse and/or neglect are reported immediately to		

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F 609	Continued From page 2 episodes, she was saying her amniotic fluid was leaking but there was nothing said about a sexual assault. She stated that Geri-psych said they were reporting it to the appropriate state agencies and she did not think she needed to. When Resident #1 was interviewed by the previous Executive Director, she stated that she didn't know why she had said that and that it had happened years ago. Resident #1 did not report to any staff members at the facility that she had been sexually assaulted. Interview with Resident #1 on 12/7/21 at 10:20 AM revealed she denied being sexually assaulted while living in the facility. She denied being abused or neglected while at the facility. Record review revealed that while Resident #1 was in geri-psych, and she reported to the social worker that she had been sexually abused by a man while at the facility. She was unclear if this man was a visitor, employee or resident. Geri-psych reported it to the Executive Director of the facility. Geri-psych social worker then reported it to Licensure and Certification. Record review of Resident #1's face sheet revealed she was admitted to the facility on 6/15/15 and with diagnoses that included Major Depressive Disorder, Bipolar disorder, Mood disorder, Intellectual disabilities, and Anxiety disorder. Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/12/21 revealed a score of 15 on her Brief Interview of Mental Status.	F 609	ensure reporting to state agencies occur within two(2)hours. Any nurse who has not completed this required education by 1/14/22 will not be allowed to return to work. The Director of Nursing will conduct an incident and accident audits five(5)times a week x 4 weeks to ensure any incidents requiring state agency notifications were reported timely beginning on 12/09/21. Any findings will be addressed and reported as required. On 12/8/21 a facility abuse and neglect procedural policy was conducted by the Interim Executive Director to the Quality Assurance Committee which consisted of but not limited to the Interim Executive Director, Director of Nursing, Social Service Director, Medical Director, Unit Manager, and Nurse Supervisors. The findings revealed no policy changes. 4. The Director of Nursing will forward the results of the audits to the Executive Director. Beginning 12/08/21 the Interim Executive Director initiated monitoring weekly times (six) 6 weeks of the incident and accident audits. The Interim Executive Director will forward the results to the Quality Assurance Committee meeting held on 01/04/22. The Quality Assurance Committee determines the frequency of audits and monitoring based upon results achieved, in addition to making recommendations and changes as needed.		