STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47157 Based on staff interviews, record review, and facility policy review the facility failed to protect one (1) of 108 residents right to be free from neglect as evidenced by [DATE] Resident #3 being unwilling to sleep in his room with his roommate due to Resident #1 getting in the bed with Resident #3. This resulted in the death of another resident (Resident #2) when Resident #1 laid on top of Resident #2 who was placed in the room with Resident #1. The facility's neglect to identify roommate incompatibility and provide appropriate person-centered behavioral interventions from [DATE]-[DATE] placed Resident #2 at risk, caused his death and placed other residents in a situation which was likely to cause serious injury, harm, impairment, or death. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on [DATE], which began on [DATE], when the facility neglected to ensure appropriate services for residents with behavioral needs. The facility's failure to provide appropriate person-centered behavioral interventions resulted in Resident #1 lying on Resident #2 until death on [DATE]. On [DATE] at 10:30 AM, the SA informed the Nursing Home Administrator of the Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) and provided the IJ Templates. The facility submitted a credible Removal Plan on [DATE], in which the facility alleged all corrective actions to remove the IJ were completed on [DATE] and the IJ removed as [DATE]. The SA validated the Removal Plan on [DATE] and determined the IJ was removed before exit. Therefore, the scope and severity for 42 CFR(s) 483.12(a)(1) - Abuse and Neglect (F600) was lowered from a J to a D while the facility develops and implements a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility policy titled, Abuse Prevention, dated ,d+[DATE] revealed: Policy: The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to facility staff, other residents .Definitions: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish Abuse may be resident -to -resident .Neglect: A failure of the facility, its employees, or service providers to provide goods and services necessary to avoid physical harm, mental anguish, emotional distress, or pain .Identification: Identify events, such as occurrences, pattens and trends that may constitute abuse; and determine the direction of the investigation . Review of the facility policy titled, Resident [NAME] of Rights revealed a facility resident shall have the right to a safe environment and the right to be free of abuse and neglect. Record review of the facility reported incident report that occurred on [DATE], at approximately 3:30 AM, the following information was found: the staff responded to the call light in Resident #1's room, and he was observed unclothed and lying on top of Resident #2. Licensed nurses and Certified Nursing Assistants (CNA) intervened. Resident #2's body fell to the floor and cardiopulmonary resuscitation (CPR) measures were initiated. The emergency management services (EMS), and police department were notified. EMS arrived at the facility at approximately 3:50 AM. The EMS continued CPR measures until 4:12 AM when they discontinued life resuscitating measures. The local police arrived at the facility at approximately 3:50 AM and interviewed Resident #1, licensed nurses and CNAs. The local police took statements and confirmed Resident #2 was deceased . The local coroner arrived to examine Resident #2's body and then removed the body from the facility. A phone interview with CNA #1 on [DATE] at 3:30 PM, revealed on the early morning of [DATE] at approximately 3:30 AM she responded to the call light going off and went into the room and observed Resident #1 naked and lying on top of Resident #2 in Resident #2's bed. She stated she instructed Resident #1 to get off of Resident #2 several times, but he would not get up, so she immediately went out into the hall and yelled for the nurse to come now, and Registered Nurse (RN) #1 came in and took over. CNA #1 revealed she had not heard any noises coming from the room that night. A phone interview with CNA #2 on [DATE] at 5:36 PM revealed she was assigned to Resident #1 and Resident #2 on the early morning of [DATE]. She stated at approximately 1:30 AM she was making rounds and observed Resident #1 was lying in bed listening to music and talking to himself which was normal behavior for both residents to have conversations with themselves, and Resident #2 was asleep in his bed. CNA #2 revealed around 3:00 AM she was making rounds and walked by the room and saw Resident #1 standing naked in front of his window but did not find that uncommon because Resident #1 often slept naked, and Resident #2 was in his bed on his side and appeared asleep. She stated that around 3:30 AM she was in an adjacent room and could hear one of the staff calling for the nurse to come help because Resident #1 was on top of Resident #2. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A phone interview with RN #1 on [DATE] at 7:30 AM, revealed on the morning of [DATE] at approximately 3:30 AM he was called to the room of Resident #1 and Resident #2. As he entered the room he observed Resident #1 lying naked on top of Resident #2 with only the hands of Resident #2 could be seen. Resident #1 was severely obese weighing 489 pounds and was covering his entire torso and head area. He stated he instructed Resident #1 to get up several times and when he did Resident #2 fell off the bed, on to the floor on his back and was not breathing. Resident #2 was a full code and CPR was immediately started, EMS was called and CPR was continued but was unable to revive Resident #2. RN #1 stated he asked Resident #1 what his date of birth and social security number were and Resident #1 answered correctly. When asked what he was doing, Resident #1 said, we were arguing and fighting I went to the nurses station and asked to call the police but we would not let him, he went back to his room and continued to argue and said Resident #2 said I am going to kill you, I took offense to that so I hit him and got on top of him. RN #1 confirmed at no time during the shift did he see Resident #1 come to the nurse's station asking to call police but stated at some point Resident #1 stated he put the call light on when Resident #2 stopped fighting him. RN #1 then stated he interviewed Resident #1 after the incident and he was alert and oriented, and answered questions appropriately. He followed RN #1's command when he asked Resident #1 to go in the bathroom and he stayed when the CPR was started. RN #1 stated Resident #1 is alert and oriented most of the time, with frequent episodes of delusional episodes. He also revealed Resident #2 had frequent episodes of delusions and talking to himself. He stated he was not made aware of concerns that night, related to the residents. RN #1 then stated he has observed Resident #1 in bed with his roommates on two other occasions in the past but was not sure of the dates and confirmed it was reported to Administration by the nurses assigned to Resident #1 immediately. RN #1 revealed that the female nursing staff call him to help when some of the male residents will not respond to them. RN #1 confirmed Resident #1 was placed on one-on-one supervision after the incident but was not on any special monitoring before the incident. Review of the facility investigation interview summary with Resident #1 under facility events for the incident that occurred on [DATE] revealed, Resident #1 was interviewed but his statement was disorganized speech, delusional, and at times nonsensical. Resident #1 told the nurse that he tried to use the phone at the nurses' station to call police before the incident but, the staff denied that he was at the nurse's station or requested to use the phone. During an interview with the Executive Director/Administrator, Director of Nursing (DON), and Regional Nurse Consultant they revealed that Resident #1 did not verbalize that he had called or tried to call the police before the incident. The information gathered from Resident #1 was that Resident #2 was tormenting him. Resident #1 said he got scared and went into the bathroom where he waited. After some time waiting in the bathroom, he said he wasn't going to wait for Resident #2 to Choke my neck. According to Resident #1 he came out of the bathroom, then he said he hit Resident #2 multiple times on the head area. Initially, Resident #1 stated he hit Resident #2 once in the back of the head when he came out of bathroom before grabbing him. Resident #1 stated they tussled and wrestled for a while on the bed where Resident #2 was bear hugging him and scratching and biting him. Resident #1 said as he was holding Resident #2 on the bed, and then Resident #2 gave up after he got on top of him. Resident #1 stated that he pressed the intercom for (staff) help. He stated that he held him down until staff could come to the room. Resident #1 also stated that he had called his dad who was working and that the police came and got his body. The resident at times rambled with disorganized speech and delusions. Resident #1 had increased delusions every time he was asked to recall the event even though there were times when his statements were consistent. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the Attorney General officer on [DATE] at 1:40 PM revealed he interviewed Resident #1 on [DATE] while Resident #1 was sitting in his chair in his room and he pointed to Resident #2's bed and stated, I killed him right over there on that bed I smothered his nose. The Attorney General officer also revealed he notified the facility on [DATE] that the sheriff's office would be picking Resident #1 up to meet with mental health services. Record review of an incident report dated [DATE] at 3:30 AM by Licensed Practical Nurse (LPN) #1 for Resident # 1 revealed, Incident description: Resident was observed lying on top of his roommate Resident #2, Resident #1 was redirected by RN #1 to go to the restroom. Resident #1 was assessed to have a scratch to his right interior shoulder measuring five inches by 0.4 inches and an abrasion to the last digit on his left hand measuring 0.2 inches by 0.2 inches. Immediate actions: Resident placed on ,d+[DATE] supervision. Mobility: Ambulates independently. Record review of the incident report dated [DATE] at 3:30 AM by LPN #1 for Resident #2 revealed Resident #1 was found on top of Resident #2. Resident #2 was not responding to name being called loudly, no movement, CPR was started until the EMT arrived and continued CPR. Unable to obtain vital signs, no pulse noted, code call stopped at 4:12 AM. Resident #2 was observed to have ,d+[DATE] inch circular abrasion to his lower right eye and his nose was misshapen. Coroner was on site and pronounced Resident #2 expired at 4:12 AM and the body was released to the Coroner. Family, responsible party, medical provider, DON and Executive Director were notified. Record review of the Behavior/Intervention Monthly Flow record for [DATE] for Resident #1 revealed behaviors to be monitored were physically/fighting aggressive, verbally aggressive (cursing), delusional, easily agitated, refusing care, and socially inappropriate with females (touching and remarks) with only one day of documentation of monitoring for the month of May which was on [DATE] and revealed no behavior noted. There was no behavior monitoring for the behavior of getting into other resident's beds. Record review the departmental note for Resident #1 revealed a note by LPN #3 dating back to [DATE] at 2:25 AM that read CNA #4 who was assigned to Resident #1 reported during her rounds Resident #1 was noted lying in bed bedside his roommate, Resident #3. Resident #1 stated he was trying to keep his roommate warm. CNA #4 reported she did not see Resident #1 do anything wrong. LPN #1 informed Resident #1 he could not get into bed with other residents. Resident #1 stated okay I was just trying to help him. The (ED) Executive Director/ Administrator, social services, and DON were notified. A phone interview with LPN #3 on [DATE] at 7:00 AM revealed she was assigned to Residents #1 and #3 on the early morning of [DATE]. She revealed CNA #4 was working the hall that night and informed her that while she was making rounds, she observed Resident #1 lying in bed with his roommate Resident # 3. Resident #3 is a deaf mute, she stated CNA #4 told her that both residents were fully clothed. LPN #3 stated that she did not think anything about it because when she asked Resident #1 why he was in the bed with Resident #3 he told her he thought that was his son and wanted to keep him warm. She stated she and CNA #4 made statements and notified the Director of Nursing and the Social Services, but she was unaware if the incident was reported and confirmed that Resident #3 was assessed and had no visible injuries. She also confirmed she did not increase monitoring of Resident #1 or notify the provider because it just did not cross her mind that Resident #1 could have attempted to abuse Resident #3 and stated, I see now why I should have recognized that. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the departmental note for Resident #1 by Social Service #1, dated [DATE] at 2:14 PM revealed the writer was informed by a nurse that a CNA reported to her she observed resident lying in bed with his roommate: resident stated he was trying to keep his room-mate warm. CNA reported she did not see the resident doing anything. Resident #1 was counseled by social services and Resident #1 voiced understanding and will observe for any further behaviors. Record review of the progress notes for Resident #1 revealed a note by LPN #2 on [DATE] at 1:22 AM that Resident #1 was observed in Resident #3's bed unclothed, refusing to get in his bed stating, there are rats over there, after multiple failed attempts to redirect resident, he finally put his mattress on the floor and laid down. A phone interview with LPN #2 on [DATE] at 5:00 PM, revealed she was assigned to Resident #1 and Resident #3 on the early morning of [DATE]. During rounds she found Resident #1 lying naked in the bed with his roommate, Resident #3, and confirmed Resident #1 had to be instructed several times to get up before he would, stating there were rats on his side of the room. She stated he finally got up and put his mattress on the floor and settled down. She revealed Resident #3 was severely cognitively impaired, a deaf mute and would not be able to call for assistance. She stated Resident #3 had a shirt and brief on at the time of the incident and was assessed to have no visible injuries. LPN #2 confirmed she notified the social worker, Administrator, the DON and confirmed she did not increase monitoring or supervision of either Resident #1 or #3 and did not notify the provider of the behavior. LPN #2 also revealed on the early morning of [DATE] she observed Resident #1 in another bed with no resident in the room and stated he did not want to go to his room because there were spiders in the room. A document provided by Social Services #1 revealed Resident #3 resided with Resident #1 from [DATE]-[DATE]. Record review of the departmental notes for Resident #3 revealed a note by LPN #3 dated [DATE] at 12:25 AM that CNA #4 had reported Resident #3's roommate was noted lying in the bed with him. Record review of the departmental notes for Resident #3 revealed a note by Social Service #1 a follow up visit related to roommate lying in bed with him. Resident is a deaf-mute unable to interview due to cognitive impairment but has not had any changes in mood, behavior, cognition or daily routine. Record review of the Face Sheet revealed the facility admitted Resident #3 on [DATE] with the diagnoses of Deaf non-speaking and Autistic disorder. Review of the departmental notes for Resident #3 revealed a note by Social Service #1 dated [DATE] at 11:09 AM that Resident #3 is being moved to another room related to roommate incompatibility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the Social Service #1 assigned to the [NAME] wing on [DATE] at 1:00 PM, revealed she was informed of the incident on [DATE] when Resident #1 was observed in Resident #3's bed. She stated that Resident #1 was clothed at the time of the incident, and she counseled him not to do that again. She stated she felt Resident #1 meant no harm because he said he thought Resident #2 was his son and was trying to keep him warm and was at times delusional. She stated she did not update Resident #1's plan of care or increase monitoring and confirmed she did not recognize this as a behavior. Social service #1 also confirmed that by not updating Resident #1's plan of care, the Interdisciplinary team not putting interventions in place to alert staff and potentially protect the residents in the facility. All residents were at risk. Resident #1 did not have increased monitoring, was ambulatory, very obese, and could have gotten into to any resident's bed, placing them at risk to be accidentally hurt or abused. Social Service #1 revealed she was not aware of the incident that occurred on [DATE], in the early morning hours, when Resident #1 was observed unclothed in Resident #3's bed. When asked if increased monitoring or treatment was put in place she stated she did not put any new interventions or monitoring in place because that was nursing's responsibility. An interview with the [NAME] President of Operations on [DATE] at 2:00 PM, revealed that the previous DON and Administrator were let go from the company on [DATE] and she was not able to find any investigations for the Resident #1 related incidents in November and December. She revealed she was unable to find any ,d+[DATE] supervision/ monitoring for Resident #1 for the Month of November and [DATE]. She provided one document of ,d+[DATE] supervision for Resident #1 that was initiated after the death of Resident #2 on the morning of [DATE]. She also confirmed that she could not find evidence were Resident #1's behavior interventions or increased monitoring were ever updated after the incidents in November and [DATE] and confirmed that the potential was there for the other residents in the facility to be at risk for harm such as being smothered if Resident #1 got into their bed. She also confirmed after review of Resident #1's Behavior/Intervention Monthly Flow Record that staff were not completing the forms correctly and it appeared the resident was not monitored for behaviors. No increased monitoring forms were provided to the SA from the facility for Resident #2 or Resident #3. An interview on [DATE] at 8:00 AM, with the previous Administrator whose last date of employment was [DATE] revealed she was not aware of any incidents of Resident #1 getting in the bed with another resident naked or clothed. She stated she would have reported and investigated it immediately because it could have been abuse and the residents in the facility are all vulnerable adults. An interview on [DATE] at 8:30 AM, with the previous DON whose last date of employment was [DATE] revealed no one had ever reported Resident #1 getting into bed with his roommate. She stated if she had that information, she would have reported it immediately and measures in place to protect both residents. An interview with the current DON on [DATE] at 9:30 AM, revealed she was not aware of Resident #1's behavior of getting into other residents' beds and was not employed at the facility during the time of the first two incidents. She confirmed the incident on ,d+[DATE] and ,d+[DATE] should have been thoroughly investigated, and interventions put in place to protect the residents. She went on to say that if after the first incident on ,d+[DATE] Resident #3, should have been moved, interventions put in place and there may not have been another incident with Resident #1 getting into resident's beds. The DON also confirmed Resident #1 should have been placed on ,d+[DATE] observation and the plan of care should have been updated for staff to be aware of the behavior to possibly intervene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the Medical Director on [DATE] at 3:00 PM revealed the facility notified him of the incident on [DATE] related to the resident-on-resident death, but confirmed he was never notified of Resident #1 ever getting into any other residents' bed clothed or unclothed. An interview with the psychiatric Nurse Practitioner (NP) on [DATE] at 3:30 PM, confirmed she was informed of the incident on [DATE] related to the death of Resident #2 but revealed she was not aware of Resident #1 getting into another resident's bed. She stated that she was aware of Resident #1's delusional/hallucinations. Record review of the psychiatric encounter notes for Resident #1 dated [DATE], [DATE], and [DATE] revealed no mention of the behavior of getting into other resident beds. An interview with the current Administrator/Executive Director on [DATE] at 8:00 AM, revealed all the incidents related to Resident #1 getting into his roommate's bed should have been thoroughly investigated. Record review of the Face Sheet the facility admitted Resident #1 on [DATE] with the diagnoses of Unspecified Mood Affective Disorder, Unspecified Psychosis, and Anxiety disorder Record review of the quarterly Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) on [DATE], revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of 7 which indicated that he was severely cognitively impaired. Section E- Mood revealed no behaviors checked. Section GG-Functional Abilities and Goals revealed resident was independent with walking. Section K-Swallowing/Nutritional Status revealed a height of 76 inches and weight of 486 pounds. Record review of the Face Sheet revealed the facility admitted Resident #2 on [DATE] with the diagnoses of Unspecified mood affective disorder, Unspecified psychosis, and Generalized anxiety disorder. Record review of the quarterly MDS Section C with an ARD on [DATE], revealed that Resident #2 had a BIMS score of 9 which indicated that he was moderately cognitively impaired. Review of the Mortician Record/Record of Death for Resident #2 dated [DATE] time of death was 4:12 AM, body was released to local Coroner's office. The facility submitted an acceptable Removal Plan for the IJ. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ: Summary of events: The facility was informed by the state agency on [DATE] at 10:30 AM of five immediate jeopardies. The state agency provided the facility with IJ template for F600, F609, F657, F689 and F742. On [DATE], Resident #1 was clothed and observed in bed with Resident #3. Resident #3 was a vulnerable, deaf, mute male Resident. The facility failed to investigate, implement interventions, and revise Resident #1's care plan for this behavior. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE], Resident #1 was observed in Resident #3 bed unclothed. Resident #3 was a vulnerable deaf, mute male Resident. The facility failed to investigate, implement interventions, and revise Resident #1's care plan for the behavior. On [DATE], at approximately 3:30 AM, the staff responded to the call light in Resident #1's room, and he was observed unclothed and lying on top of Resident #2. licensed nurses and certified nursing assistants intervened. Resident #2's body fell to the floor and cardiopulmonary resuscitation measures (CPR) were initiated. The emergency management services (EMS), and police department were notified. EMS arrived at the facility at approximately 3:50 AM. The emergency management services continued cardiopulmonary resuscitation measures until 4:12 AM and discontinued life resuscitating measures. The local police arrived at the facility at approximately 3:50 AM and interviewed Resident # 1, licensed nurses and certified nursing assistants (CNA). The local police took statements and confirmed Resident # 2 was deceased . The local coroner arrived to examine Resident # 2's body and removed the body from the facility with the understanding that an autopsy would be completed to determine the final cause of death. Corrective Actions: 1. On [DATE] Resident #1 was placed on one-on- one (,d+[DATE]) supervision immediately. Psychiatric placement was initiated on [DATE] at approximately 8:00 am but was unsuccessful. A telehealth visit was conducted with the psychiatric nurse practitioner on [DATE] at approximately 12:00 PM. Resident #1 remained on ,d+[DATE] supervision until he was discharged to the custody of the local police department on [DATE] at 3:45 PM. 2. The Administrator presented to the facility on [DATE] at approximately 4:40 AM and initiated an investigation with assigned licensed nurses and certified nursing assistants. 3. On [DATE] The Administrator notified the MS State Department of Health at 5:50 AM, Attorney General Office at 9:00 PM and Ombudsman on [DATE] at 11:08 AM. 4. An in-service was initiated for all staff on [DATE] at approximately 5:30 AM regarding supervision of accidents and incidents, abuse/neglect, how to handle resident to resident altercations, reporting of any resident with delusional behaviors or verbalizing harmful behaviors to others, how to deal with aggressive behaviors. 5. A special resident council meeting was conducted on [DATE] 11:30 AM by the Administrator and Director of Nurses to ensure that the facility's residents felt safe. 21 out of 21 Residents verbalized feeling safe in the facility. 6. On [DATE] at approximately 3:30 PM, the social service department completed a 100% audit on roommate compatibility. 100% of the roommates were compatible or chose to be roommates. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. On [DATE] an in-service was initiated at approximately 10:00 am by the [NAME] President of Operations for all staff on prevention/supervision of accidents, abuse/neglect, abuse reporting, resident rights, implementing interventions to prevent reoccurrence and updating care plans to reflect interventions and monitoring of behaviors. In-service details: When residents are observed in another resident's bed to immediately intervene and separate. The staff was instructed to notify the nurse immediately and protect the alleged victim by remaining 1-on-1 supervision with the alleged aggressor. The nurses were instructed to immediately perform head to toe skin assessments for both Residents while ensuring and notifying the Executive Director and Director of Nurses. The Administrator and Director of Nurses were instructed to ensure that a thorough investigation is completed and reported to the state agencies. The Administrator and Director of Nurses was instructed to ensure that interventions are put in place to protect other Residents and the alleged aggressor's care plan is updated and behavior is monitoring is in place. In-service also included notifying the nurse, Administrator, and Director of nurses immediately if any Resident verbalize or exhibits delusional behaviors that are harmful towards others. No staff will be allowed to work until the in-service is received. 8. On [DATE] at 9:00 AM, the [NAME] President of Operations in serviced the Administrator and Director of Nurses on abuse/neglect and ensuring to investigate and report all instances of abuse/neglect to regulatory agencies. 9. On [DATE] at 10:15 AM, the [NAME] President of Operations in serviced the social service department on ensuring that care plans are revised to reflect interventions and behaviors are monitored. 10. On [DATE] at approximately 11:30 AM, an interview was initiated for 28 cognitive residents to determine if they have incurred any issues with other residents lying in their beds. 28 of 28 Residents denied any concerns. 11. A 100% audit was initiated on [DATE] at 1:30 PM by the social services department to ensure that all Residents had compatible roommates. No issues identified. 12. A 100% audit was conducted on [DATE] at 2:00 PM by the social services department to ensure that Residents' behaviors are care planned and monitoring is in place. 13. The Administrator reported the [DATE] incident involving Resident #1 and Resident #3 to the Mississippi State Department of Health at 2:13 PM on [DATE]. 14. An emergency quality assurance committee met on [DATE] at 2:50 PM. The attendees of the meeting were the Administrator, Director of Nurses, Assistant Director of Nurses, Social Services Assistant, Staff Development Coordinator, Nurse Practitioner, Regional Clinical Operations Nurse, and Regional [NAME] President. The facility discussed the current survey IJ outcomes. 5 IJ were cited for abuse/neglect, abuse reporting, revision of care plans, behavioral monitoring, and accidents/incidents. Upon investigation, Resident #1 had previous behavioral issues on [DATE] with Resident #3. Resident # 1 was unclothed. The facility failed to report, investigate and implement interventions based on the behaviors. In-services modified as of [DATE] to include protecting residents from others who get into their beds by intervening and providing 1-on-1 supervision. In addition, reporting and investigating alleged events. All policies were reviewed for accidents/incidents, abuse prevention, revision of care plans, behavioral monitoring. No changes required. 14. The Ombudsman was notified of the [DATE] on [DATE] at 3:27 PM by the Administrator. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	15. The Administrator reported the [DATE] incident involving Resident #1 and Resident # 3 to the Attorney General Office online system on [DATE] at 3:40 PM. Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of [DATE] and the Immediate Jeopardy was removed [DATE]. Validation: The SA Validations were made onsite during the complaint investigation CI MS #25192. On [DATE], the SA validated through interviews and record reviews that all corrective actions had been taken by the facility to remove the IJ and the IJ was removed on [DATE].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47157 Based on staff interview, care plan review, record review, and facility policy review, the facility failed to revise a comprehensive care plan related to behaviors for (1) one of 13 residents reviewed for care plans. Resident #1 The facility's failure to revise Resident #1's care plans with appropriate interventions related to his known behavior of getting into bed with other residents resulted in staff not having access to preventative measures to deter this behavior. On [DATE], Resident #1 was found in bed on top of Resident #2 with only his hands visible beneath Resident #1. Resident #2 was unresponsive and did not respond to life sustaining measures and was pronounced dead. This placed the residents residing in the facility at risk, and in a situation that was likely to cause serious injury, harm, impairment, or death. The State Agency (SA) identified an Immediate Jeopardy (IJ) on [DATE], which began on [DATE] when the facility failed to revise Resident #1's behavior care plan. On [DATE] at 10:30 AM, the SA informed the Nursing Home Administrator of the Immediate Jeopardy (IJ) and provided the IJ Template. The facility submitted a credible Removal Plan on [DATE], in which the facility alleged all corrective actions to remove the IJ were completed on [DATE] and the IJ removed as of [DATE]. The SA validated the Removal Plan on [DATE] and determined the IJ was removed prior to exit. Therefore, the scope and severity for 42 CFR(s) 483.21(b)(2)(iii) Care plan Timing and Revision Care Plans (F657) - Scope and Severity - J, was lowered from an J to a D while the facility develops and implements 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 policy titled, Comprehensive Person Centered Care Plans, revised ,d+[DATE], revealed: Policy: 9.) Upon a change in condition, the comprehensive person-centered care plan will be updated .' Record review of the Care Plan for Resident #1 with a problem onset date of [DATE] revealed, Problem/Need I am delusional, easily agitated, verbally/physically aggressive at times, refuses care (showers, shaves, and personal hygiene) and socially inapp. (inappropriate) with females staff (touching and remarks). Takes mattress off bed puts mattress on floor and sleeps on it . The care plan did not include a revision to the problem/need or approaches to address the behavior of Resident #1 getting into other resident's beds. Record review of the Departmental Notes for Resident #1 revealed a note by Licensed Practical Nurse (LPN) #3 on [DATE] at 2:25 AM revealed CNA #4 reported while she was making rounds Resident #1 was noted lying in bed bedside his roommate. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the Departmental Note for Resident #1 revealed a note written by LPN #2 on [DATE] at 1:22 AM that Resident #1 was observed in Resident #3's bed unclothed, refusing to get in his bed stating, there are rats over there, after multiple failed attempts to redirect Resident #1 he finally put his mattress on the floor and laid down. In an interview and record review with Social Service #1 assigned to the [NAME] wing on [DATE] at 1:00 PM, she revealed she did not update Resident #1's plan of care or increase monitoring. Social service #1 also confirmed that by not updating Resident #1's plan of care and the Interdisciplinary team not putting interventions in place to alert staff and potentially protect the residents in the facility, all residents were at risk because Resident # 1 did not have increased monitoring and was ambulatory, very obese, and could have gotten into to any residents bed placing them at risk to be accidentally hurt or abused. Social Service #1 confirmed after review of Resident #1's behavior plan of care that it had never been updated to reflect the behavior of Resident #1 getting into other resident's beds and confirmed by not increasing monitoring and supervision of Resident #1's behaviors the facility did not protect the other residents from harm. Social Service #1 revealed the purpose of the care plan is to aid staff to provide person-centered care and treatment to meet the resident's specific needs. In an interview with the current Director of Nurses (DON) on [DATE] at 9:30 AM, she confirmed Resident #1 should have been placed on 1-on-1 observation and the plan of care should have been updated for staff to be aware of the behavior to possibly intervene. In an interview with the current Administrator on [DATE] at 8:00 AM, he revealed all the incidents related to Resident #1's behavior of getting into his roommate's bed should have been updated in the plan of care. Record review of the Face Sheet revealed the facility admitted Resident #1 on [DATE] with diagnoses that included Unspecified mood affective disorder, Unspecified psychosis, and Anxiety Disorder. Record review of the quarterly Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) on [DATE], revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of 7 which indicated that he was severely cognitively impaired. Section E- Mood revealed no behaviors were checked. Section GG-Functional Abilities and Goals revealed the resident was independent with walking. Section K-Swallowing/Nutritional Status revealed a height of 76 inches and weight of 486 pounds. The facility submitted an acceptable Removal Plan for the IJ. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ: Summary of events: The facility was informed by the state agency on [DATE] at 10:30 AM of five immediate jeopardies. The state agency provided the facility with IJ template for F600, F609, F657, F689 and F742. On [DATE], Resident #1 was clothed and observed in bed with Resident # 3. Resident # 3 was a vulnerable, deaf, mute male Resident. The facility failed to investigate, implement interventions, and revise Resident # 1's care plan for this behavior. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE], Resident # 1 was observed in Resident #3 bed unclothed. Resident # 3 was a vulnerable deaf, mute male Resident. The facility failed to investigate, implement interventions, and revise Resident #1's care plan for the behavior. On [DATE], at approximately 3:30 AM, the staff responded to the call light in Resident # 1's room, and he was observed unclothed and lying on top of Resident # 2. Licensed nurses and certified nursing assistants intervened. Resident # 2's body fell to the floor and cardiopulmonary resuscitation measures (CPR) were initiated. The emergency management services (EMS), and police department were notified. EMS arrived at the facility at approximately 3:50 AM. The emergency management services continued cardiopulmonary resuscitation measures until 4:12 AM and discontinued life resuscitating measures. The local police arrived at the facility at approximately 3:50 AM and interviewed Resident # 1, licensed nurses and certified nursing assistants (CNA). The local police took statements and confirmed Resident # 2 was deceased . The local coroner arrived to examine Resident # 2's body and removed the body from the facility with the understanding that an autopsy would be completed to determine the final cause of death. Corrective Actions: 1. On [DATE] Resident # 1 was placed on one-on- one (,d+[DATE]) supervision immediately. Psychiatric placement was initiated on [DATE] at approximately 8:00 am, but was unsuccessful. A telehealth visit was conducted with the psychiatric nurse practitioner on [DATE] at approximately 12:00 PM. Resident #1 remained on ,d+[DATE] supervision until he was discharged to the custody of the local police department on [DATE] at 3:45 PM. 2. The Administrator presented to the facility on [DATE] at approximately 4:40 AM and initiated an investigation with assigned licensed nurses and certified nursing assistants. 3. On [DATE] The Administrator notified the MS State Department of Health at 5:50 AM, Attorney General Office at 9:00 PM and Ombudsman on [DATE] at 11:08 AM. 4. An in-service was initiated for all staff on [DATE] at approximately 5:30 AM regarding supervision of accidents and incidents, abuse/neglect, how to handle resident to resident altercations, reporting of any resident with delusional behaviors or verbalizing harmful behaviors to others, how to deal with aggressive behaviors. 5. A special resident council meeting was conducted on [DATE] 11:30 AM by the Administrator and Director of Nurses to ensure that the facility's residents felt safe. 21 out of 21 Residents verbalized feeling safe in the facility. 6. On [DATE] at approximately 3:30 PM, the social service department completed a 100% audit on roommate compatibility. 100% of the roommates were compatible or chose to be roommates. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. On [DATE] an in-service was initiated at approximately 10:00 am by the [NAME] President of Operations for all staff on prevention/supervision of accidents, abuse/neglect, abuse reporting, resident rights, implementing interventions to prevent reoccurrence and updating care plans to reflect interventions and monitoring of behaviors. In-service details: When residents are observed in another resident's bed to immediately intervene and separate. The staff was instructed to notify the nurse immediately and protect the alleged victim by remaining 1-on-1 supervision with the alleged aggressor. The nurses were instructed to immediately perform head to toe skin assessments for both Residents while ensuring and notifying the Executive Director and Director of Nurses. The Administrator and Director of Nurses were instructed to ensure that a thorough investigation is completed and reported to the state agencies. The Administrator and Director of Nurses were instructed to ensure that interventions are put in place to protect other Residents and the alleged aggressor's care plan is updated and behavior is monitoring is in place. In-service also included notifying the nurse, Administrator, and Director of nurses immediately if any Resident verbalize or exhibits delusional behaviors that are harmful towards others. No staff will be allowed to work until the in-service is received. 8. On [DATE] at 9:00 AM, the [NAME] President of Operations in serviced the Administrator and Director of Nurses at 9:00 AM on abuse/neglect and ensuring to investigate and report all instances of abuse/neglect to regulatory agencies. 9. On [DATE] at 10:15 AM, the [NAME] President of Operations in serviced the social service department on ensuring that care plans are revised to reflect interventions and behaviors are monitored. 10. On [DATE] at approximately 11:30 AM, an interview was initiated for 28 cognitive residents to determine if they have incurred any issues with other residents lying in their beds. 28 of 28 Residents denied any concerns. 11. A 100% audit was initiated on [DATE] at 1:30 PM by the social services department to ensure that all Residents had compatible roommates. No issues identified. 12. A 100% audit was conducted on [DATE] at 2:00 PM by the social services department to ensure that Residents' behaviors are care planned and monitoring is in place. 13. The Administrator reported the [DATE] incident involving Resident # 1 and Resident # 3 to the MS State Department of Health at 2:13 PM on [DATE]. 14. An emergency quality assurance committee met on [DATE] at 2:50 PM. The attendees of the meeting were the Administrator, Director of Nurses, Assistant Director of Nurses, Social Services Assistant, Staff Development Coordinator, Nurse Practitioner, Regional Clinical Operations Nurse, and Regional [NAME] President. The facility discussed the current survey IJ outcomes. 5 IJ cites for abuse/neglect, abuse reporting, revision of care plans, behavioral monitoring, and accidents/incidents. Upon investigation, Resident # 1 had previous behavioral issues on [DATE] with Resident # 3. Resident # 1 was unclothed. The facility failed to report, investigate and implement interventions based on the behaviors. In-services modified as of [DATE] to include protecting residents from others who get into their beds by intervening and providing 1-on-1 supervision. In addition, reporting and investigating alleged events. All policies were reviewed for accidents/incidents, abuse prevention, revision of care plans, behavioral monitoring. No changes required. 14. The Ombudsman was notified of the [DATE] on [DATE] at 3:27 PM by the Administrator. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	15. The Administrator reported the [DATE] incident involving Resident # 1 and Resident # 3 to the Attorney General Office online system on [DATE] at 3:40 PM. The facility is alleging that all activities to remove the Immediate Jeopardy were completed as of [DATE] and the Immediate Jeopardy was removed on [DATE]. Validation: SA Validations were made onsite during the complaint investigation CI MS #25192. On [DATE], the SA surveyor verified through staff and resident interview, record review, sign-in sheets, and in-service reviews that all corrective actions had been taken by the facility to remove the IJ during the survey on [DATE] and the IJ was removed on [DATE].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47157 Based on record review, staff interviews, and facility policy review, the facility failed to provide adequate supervision to reduce the risk of an accident/hazards when a resident with behaviors got into other resident's beds and did not have any increased supervision/monitoring put in place resulting, in the physical assault and death of a resident for (1) one of (4) four residents reviewed for accidents. (Resident #2) The facility's failure to provide adequate supervision and monitoring, placed Resident #2 and other residents residing in the facility at risk, and in a situation which caused Resident #2's death and was likely to cause serious injury, serious harm, serious impairment, or death for others. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on [DATE], which began on [DATE], when the facility failed to provide increased supervision/monitoring and ensure appropriate services for residents with behavioral needs. The facility's failure to provide supervision/monitoring, resulted in the physical assault and death of a resident on [DATE]. On [DATE] at 10:30 AM, the SA informed the Nursing Home Administrator of the Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) and provided the IJ Templates. The facility submitted a credible Removal Plan on [DATE], in which the facility alleged all corrective actions to remove the IJ were completed on [DATE] and the IJ removed as of [DATE]. The SA validated the Removal Plan on [DATE] and determined the IJ was removed before exit. Therefore, the scope and severity for 42 CFR(s) 483.25(d)(1)(2)- Free of accidents/hazards/supervision/devices (F689) Scope and Severity -J, was lowered from a J to a D while the facility develops and implements 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 of the facility policy Accident & Incident Documentation & Investigation Resident Incident reviewed ,d+[DATE] revealed POLICY: Accidents and/or incidents involving resident care will .be analyzed for trends or patterns to enable the facility to enhance preventative measures to reduce the occurrence of incidents . Record review of an incident report dated [DATE], at approximately 3:30 AM, the staff responded to the call light in Resident # 1's room, and he was observed unclothed and lying on top of Resident #2. Licensed nurses and Certified Nursing Assistants (CNAs) intervened. Resident #2's body fell to the floor and cardiopulmonary resuscitation measures (CPR) was initiated. The emergency management services (EMS) and the police department were notified. EMS arrived at the facility at approximately 3:50 AM. EMS continued CPR until 4:12 AM and then discontinued life resuscitating measures. The local police arrived at the facility at approximately 3:50 AM and interviewed Resident #1, licensed nurses and CNAs. The local police took statements and confirmed Resident #2 was deceased . The local coroner arrived to examine Resident # 2's body and then removed the body. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the Face Sheet revealed the facility admitted Resident #1 on [DATE] with the diagnoses that included Unspecified mood affective disorder, Unspecified psychosis, and Anxiety Disorder. Record review of the quarterly Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of [DATE], revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of 7 which indicated that he was severely cognitively impaired. Section E- Mood revealed no behaviors checked. Section GG-Functional Abilities and Goals revealed the resident was independent with walking. Section: K-Swallowing/Nutritional Status revealed a height of 76 inches and weight of 486 pounds. Record review of the Face Sheet revealed the facility admitted Resident #2 on [DATE] with the diagnoses of Unspecified Mood Affective disorder, Unspecified Psychosis, and Generalized Anxiety disorder. Record review of the quarterly MDS Section C with an ARD on [DATE], revealed that Resident #2 had a BIMS score of 9 which indicated that he was moderately cognitively impaired. On [DATE] at 7:30 AM, during a phone interview with Registered Nurse (RN) #1 revealed on the morning of [DATE] at approximately 3:30 AM he was called to the room of Resident #1 and Resident #2 and observed Resident #1 lying naked on top of Resident #2 with only the hands of Resident #2 could be seen. RN #1 revealed Resident #1 was severely obese, weighing 489 pounds, covering Resident #2's entire torso and head. RN #1 confirmed Resident #1 was placed on one-on-one monitoring after the incident, but was not on any special monitoring before the incident. Record review of the coroner report, revealed Resident #2 was pronounced deceased on [DATE] at 4:12 AM and then released to the coroner's office. Review of the Departmental Notes for Resident #1 revealed a note by Licensed Practical Nurse (LPN) #3 on [DATE] at 2:25 AM, CNA #4 reported while she was making rounds Resident #1 was noted lying in bed bedside roommate, Resident #3. Resident #1 stated he was trying to keep his roommate warm. LPN #2 informed Resident #1 he could not get into bed with other residents. Resident #1 stated, okay, I was just trying to help him. On [DATE] at 7:00 AM, in a phone interview LPN #3 revealed on the early morning of [DATE] CNA #4 that was working the hall that night informed her that while she was making rounds, she observed Resident #1 lying in bed with his roommate Resident # 3, who is a deaf mute. She also confirmed she did not increase monitoring of Resident #1 because it just did not cross her mind that Resident #1 could have attempted to abuse Resident #3 stating I see now why I should have recognized that. Record review of the Departmental Note for Resident #1 revealed a note by Social Service #1 dated [DATE] at 2:14 PM revealed the writer was informed by a nurse that a CNA reported to her, she observed Resident #1 lying in bed with his roommate: Resident #1 stated he was trying to keep his roommate warm. The CNA reported she did not see the resident doing anything. The resident was counseled by social services and the resident voiced understanding and will observe for any further behaviors. Record review of the Departmental Note for Resident #1 revealed a note by LPN #2 on [DATE] at 1:22 AM Resident #1 was observed in roommate's bed unclothed, refusing to get in his bed stating, there are rats over there, after multiple failed attempts to redirect he finally put his mattress on the floor and laid down. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 5:00 PM, a phone interview with LPN #2 revealed on the early morning of [DATE] she found Resident #1 lying naked in the bed with Resident #3. She confirmed she did not increase monitoring of either Resident #1 or Resident #3. On [DATE] at 1:00 PM, in an interview with the Social Service staff #1 assigned to the [NAME] wing on [DATE] revealed she was informed of the incident on [DATE] early in the morning hours when Resident #1 was observed in Resident #3's bed. Social Service #1 stated she did not update Resident #1's increase monitoring and confirmed she did not recognize this as a behavior. Social Service #1 also confirmed that by not putting interventions/increased monitoring in place to alert staff and potentially protect the residents in the facility, all residents were at risk. Due to Resident #1 was ambulatory, very obese, and could have gotten into to any resident's bed placing them at risk to be accidentally hurt. When asked if increased monitoring or treatment was put in place after the incident on [DATE], she stated she did not put any new interventions or monitoring in place because that was nursing's responsibility. Record review of the Departmental Notes for Resident #3 revealed a note by Social Service #1 dated [DATE] at 11:09 AM, that resident is being moved related to roommate incompatibility. Record review of the Face Sheet revealed the facility admitted Resident #3 on [DATE] with the diagnoses of Deaf non-speaking and Autistic disorder. On [DATE] at 2:00 PM, an interview with the [NAME] President of Operations, revealed she was unable to find any ,d+[DATE] supervision/monitoring for Resident #1 related to the incidents in November and [DATE]. She provided a document of ,d+[DATE] supervision for Resident #1 that was initiated after the death of Resident #2 on the morning of [DATE]. She also confirmed that she could not find evidence where Resident #1's behavior interventions/ monitoring were updated after the incidents in November and [DATE]. She also confirmed that the potential was there for the other residents in the facility to be at risk of harm, such as being smothered if Resident #1 got into their bed. No increased monitoring forms were provided to the SA from the facility for Resident #2 or Resident #3. Record review of the Resident Location Monitoring form for Resident #1 provided by the facility, revealed resident to only be on increased monitoring 1-on 1 supervision starting at 3:45 AM on [DATE] -3:45 PM on [DATE] when Resident #1 was released to the Sheriff's department. The facility submitted an acceptable Removal Plan for the IJ. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ: Summary of events: The facility was informed by the state agency on [DATE] at 10:30 AM of five immediate jeopardies. The state agency provided the facility with IJ template for F600, F609, F657, F689 and F742. On [DATE], Resident #1 was clothed and observed in bed with Resident # 3. Resident # 3 was a vulnerable, deaf, mute male Resident. The facility failed to investigate, implement interventions, and revise Resident #1's care plan for this behavior. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE], Resident # 1 was observed in Resident #3 bed unclothed. Resident # 3 was a vulnerable deaf, mute male Resident. The facility failed to investigate, implement interventions, and revise Resident #1's care plan for the behavior. On [DATE], at approximately 3:30 AM, the staff responded to the call light in Resident # 1's room, and he was observed unclothed and lying on top of Resident # 2. Licensed nurses and certified nursing assistants intervened. Resident # 2's body fell to the floor and cardiopulmonary resuscitation measures (CPR) were initiated. The emergency management services (EMS), and police department were notified. EMS arrived at the facility at approximately 3:50 AM. The emergency management services continued cardiopulmonary resuscitation measures until 4:12 AM and discontinued life resuscitating measures. The local police arrived at the facility at approximately 3:50 AM and interviewed Resident # 1, licensed nurses and certified nursing assistants (CNA). The local police took statements and confirmed Resident # 2 was deceased . The local coroner arrived to examine Resident # 2's body and removed the body from the facility with the understanding that an autopsy would be completed to determine the final cause of death. Corrective Actions: 1. On [DATE] Resident # 1 was placed on one-on- one (,d+[DATE]) supervision immediately. Psychiatric placement was initiated on [DATE] at approximately 8:00 am but was unsuccessful. A telehealth visit was conducted with the psychiatric nurse practitioner on [DATE] at approximately 12:00 PM. Resident #1 remained on ,d+[DATE] supervision until he was discharged to the custody of the local police department on [DATE] at 3:45 PM. 2. The Administrator presented to the facility on [DATE] at approximately 4:40 AM and initiated an investigation with assigned licensed nurses and certified nursing assistants. 3. On [DATE] The Administrator notified the MS State Department of Health at 5:50 AM, Attorney General Office at 9:00 PM and Ombudsman on [DATE] at 11:08 AM. 4. An in-service was initiated for all staff on [DATE] at approximately 5:30 AM regarding supervision of accidents and incidents, abuse/neglect, how to handle resident to resident altercations, reporting of any resident with delusional behaviors or verbalizing harmful behaviors to others, how to deal with aggressive behaviors. 5. A special resident council meeting was conducted on [DATE] 11:30 AM by the Administrator and Director of Nurses to ensure that the facility's residents felt safe. 21 out of 21 Residents verbalized feeling safe in the facility. 6. On [DATE] at approximately 3:30 PM, the social service department completed a 100% audit on roommate compatibility. 100% of the roommates were compatible or chose to be roommates. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. On [DATE] an in-service was initiated at approximately 10:00 am by the [NAME] President of Operations for all staff on prevention/supervision of accidents, abuse/neglect, abuse reporting, resident rights, implementing interventions to prevent reoccurrence and updating care plans to reflect interventions and monitoring of behaviors. In-service details: When residents are observed in another resident's bed to immediately intervene and separate. The staff was instructed to notify the nurse immediately and protect the alleged victim by remaining 1-on-1 supervision with the alleged aggressor. The nurses were instructed to immediately perform head to toe skin assessments for both Residents while ensuring and notifying the Executive Director and Director of Nurses. The Administrator and Director of Nurses were instructed to ensure that a thorough investigation is completed and reported to the state agencies. The Administrator and Director of Nurses was instructed to ensure that interventions are put in place to protect other Residents and the alleged aggressor's care plan is updated and behavior is monitoring is in place. In-service also included notifying the nurse, Administrator, and Director of nurses immediately if any Resident verbalize or exhibits delusional behaviors that are harmful towards others. No staff will be allowed to work until the in-service is received. 8. On [DATE] at 9:00 AM, the [NAME] President of Operations in serviced the Administrator and Director of Nurses at 9:00 AM on abuse/neglect and ensuring to investigate and report all instances of abuse/neglect to regulatory agencies. 9. On [DATE] at 10:15 AM, the [NAME] President of Operations in serviced the social service department on ensuring that care plans are revised to reflect interventions and behaviors are monitored. 10. On [DATE] at approximately 11:30 AM, an interview was initiated for 28 cognitive residents to determine if they have incurred any issues with other residents lying in their beds. 28 of 28 Residents denied any concerns. 11. A 100% audit was initiated on [DATE] at 1:30 PM by the social services department to ensure that all Residents had compatible roommates. No issues identified. 12. A 100% audit was conducted on [DATE] at 2:00 PM by the social services department to ensure that Residents' behaviors are care planned and monitoring is in place. 13. The Administrator reported the [DATE] incident involving Resident # 1 and Resident # 3 to the MS State Department of Health at 2:13 PM on [DATE]. 14. An emergency quality assurance committee met on [DATE] at 2:50 PM. The attendees of the meeting were the Administrator, Director of Nurses, Assistant Director of Nurses, Social Services Assistant, Staff Development Coordinator, Nurse Practitioner, Regional Clinical Operations Nurse, and Regional [NAME] President. The facility discussed the current survey IJ outcomes. 5 IJ cites for abuse/neglect, abuse reporting, revision of care plans, behavioral monitoring, and accidents/incidents. Upon investigation, Resident # 1 had previous behavioral issues on [DATE] with Resident # 3. Resident # 1 was unclothed. The facility failed to report, investigate and implement interventions based on the behaviors. In-services modified as of [DATE] to include protecting residents from others who get into their beds by intervening and providing 1-on-1 supervision. In addition, reporting and investigating alleged events. All policies were reviewed for accidents/incidents, abuse prevention, revision of care plans, behavioral monitoring. No changes required. 14. The Ombudsman was notified of the [DATE] on [DATE] at 3:27 PM by the Administrator. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	15. The Administrator reported the [DATE] incident involving Resident # 1 and Resident # 3 to the Attorney General Office online system on [DATE] at 3:40 PM. Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of [DATE] and the Immediate Jeopardy was removed [DATE]. Validation: SA Validations were made onsite during the complaint investigation (CI) MS #25192. On [DATE], the SA surveyor verified through staff and resident interview, record review, sign-in sheets, and in-service reviews that all corrective actions had been taken by the facility to remove the IJ during the survey on [DATE] and the IJ was removed on [DATE].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47157 Based on staff interviews, record review, and facility policy review, the facility failed to recognize behaviors and provide appropriate person-centered behavioral interventions for one (1) of three (3) residents with documented behaviors resulting in the physical assault and death of a resident. (Resident #1) The facility's failure to identify behaviors and failure to provide appropriate person-centered behavioral interventions and supervision, from [DATE] through [DATE] resulted in the death of Resident #2 and placed other residents at risk, and in a situation which was likely to cause serious injury, harm, impairment, or death. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on [DATE], which began on [DATE], when the facility failed to identify behaviors, and ensure appropriate services for residents with behavioral needs. The facility's failure to identify potential abuse, failure to provide appropriate person-centered behavioral interventions and supervision resulted in the physical assault and death of a resident on [DATE]. On [DATE] at 10:30 AM, the SA informed the Nursing Home Administrator of the Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) and provided the IJ Templates. The facility submitted a credible Removal Plan on [DATE], in which the facility alleged all corrective actions to remove the IJ were completed on [DATE] and the IJ removed as of [DATE]. The SA validated the Removal Plan on [DATE] and determined the IJ was removed before exit. Therefore, the scope and severity for 42 CFR(s) 483.40 (b)(1) Treatment/services Mental/Psychosocial (F742) - Scope and Severity - J, was lowered from an J to a D while the facility develops and implements a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: A review of the facility policy titled, Behavior Management and Psycho-pharmacological Medication Monitoring Protocol, reviewed ,d+[DATE], revealed: Behavioral Interventions: are individualized non-pharmacological approaches to care as a part of a supportive physical and psychosocial environment, and are directed toward understanding, preventing, relieving, and or accommodating a resident's distress or loss of abilities as well as maintaining or improving a resident's mental, physical or psychosocial well being . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of an incident report dated [DATE], at approximately 3:30 AM, revealed the staff responded to the call light in Resident # 1's room, and he was observed unclothed and lying on top of Resident #2. Licensed nurses and Certified Nursing Assistants (CNAs) intervened. Resident #2's body fell to the floor and cardiopulmonary resuscitation measures (CPR) was initiated. The emergency management services (EMS) and the police department were notified. EMS arrived at the facility at approximately 3:50 AM. EMS continued CPR until 4:12 AM and then discontinued life resuscitating measures. The local police arrived at the facility at approximately 3:50 AM and interviewed Resident #1, licensed nurses and CNAs. The local police took statements and confirmed Resident #2 was deceased . The local coroner arrived to examine Resident # 2's body and then removed the body. Record review of the Behavior/Intervention Monthly Flow record for [DATE] for Resident #1 revealed behaviors to be monitored were physically/fighting aggressive, verbally aggressive (cursing), delusional, easily agitated, refusing care, and socially inappropriate with females (touching and remarks). There was no documentation of Residents #1's behavior of getting into other resident's beds listed to be monitored on the flow record. There was only one day of monitoring documentation on [DATE] for the month of May. Record review of the Face Sheet revealed the facility admitted Resident #1 on [DATE] with diagnoses that included Unspecified Mood Affective disorder, Unspecified Psychosis, and Anxiety disorder. Record review of the quarterly Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of [DATE], revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 7 which indicated that he was severely cognitively impaired. Section E- Mood revealed no behaviors checked. Section GG-Functional Abilities and Goals revealed the resident was independent with walking. Section: K-Swallowing/Nutritional Status revealed a height of 76 inches and weight of 486 pounds. Record review of the quarterly MDS Section C with an ARD on [DATE], revealed that Resident #2 had a BIMS score of 9 which indicated he had moderate cognitive impairment During a telephone interview with Registered Nurse (RN) #1 on [DATE] at 7:30 AM, confirmed on the morning of [DATE] at approximately 3:30 AM Resident #1 was placed on one-on-one monitoring but confirmed the resident was not on any special monitoring before the incident. Record review of the Departmental Note for Resident #1 revealed a note written by Licensed Practical Nurse (LPN) #3 on [DATE] at 2:25 AM, CNA #4 reported while she was making rounds that Resident #1 was noted lying in bed bedside roommate Resident #3. Resident #1 stated he was trying to keep his roommate warm. LPN #3 informed Resident he could not get into bed with other residents. Resident #1 stated, okay, I was just trying to help him. Record review of the Face Sheet revealed the facility admitted Resident #3 on [DATE] with diagnoses that included Deaf non-speaking and Autistic disorder. During a phone interview on [DATE] at 7:00 AM, LPN #3 revealed she was assigned to Resident #1 and #3 on the early morning of [DATE] and confirmed she did not increase monitoring of Resident #1 because it just did not cross her mind that Resident #1 could have attempted to abuse Resident #3. LPN #3 stated I see now why I should have recognized that. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the Departmental Note for Resident #1by Social Service (SS) #1 dated [DATE] at 2:14 PM revealed, the writer was informed by a nurse that a CNA reported to her, she observed Resident #1 lying in bed with his roommate. Resident #1 stated he was trying to keep his roommate warm. The CNA reported she did not see the resident doing anything. Resident #1 was counseled by SS and the resident voiced understanding and will observe for any further behaviors. Record review of the Progress Notes for Resident #1 revealed a note by LPN #2 on [DATE] at 1:22 AM Resident #1 was observed in roommate's bed unclothed, refusing to get in his bed stating, there are rats over there, after multiple failed attempts to redirect Resident #1 finally put his mattress on the floor and laid down. During a telephone interview with LPN #2 on [DATE] at 5:00 PM, she revealed she was assigned to Resident #1 and Resident #3 on the early morning of [DATE] and confirmed she did not increase monitoring of either Resident #1 or #3 and did not notify the provider of the behavior. During an interview with the Social Service #1 on [DATE] at 1:00 PM, she revealed she was informed of the incident on [DATE], and she counseled Resident #1 not to do that again. She stated she felt Resident #1 meant no harm because he said he thought Resident #3 was his son and trying to keep him warm and was at times delusional. During a record review and interview with the [NAME] President of Operations on [DATE] at 2:00 PM, she revealed she was unable to find any 1:1 supervision monitoring for Resident #1 for the months of November and [DATE] at the time of the incidents. She provided only one document of 1:1 supervision for Resident #1 that was initiated after the death of Resident #2 on the morning of [DATE]. She also confirmed after review of Resident #1's behavior monitoring forms that staff were not completing the forms correctly, and it appeared the Resident was not monitored for behaviors. During an interview with the current Director of Nursing (DON) on [DATE] at 9:30 AM, she confirmed interventions should have been put in place for the incidents that occurred in November and [DATE] to protect the residents. She went on to say that if after the first incident on [DATE] Resident #3 was moved and interventions were put in place there may not have been another incident with Resident #1 getting into resident's beds. She confirmed Resident #1 should have been placed on 1-on-1 observation and the plan of care should have been updated for staff to be aware of the behavior to possibly intervene. The facility submitted an acceptable Removal Plan for the IJ on [DATE]. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ: Summary of events: The facility was informed by the state agency on [DATE] at 10:30 AM of five immediate jeopardies. The state agency provided the facility with IJ template for F600, F609, F657, F689 and F742. On [DATE], Resident #1 was clothed and observed in bed with Resident # 3. Resident # 3 was a vulnerable, deaf, mute male Resident. The facility failed to investigate, implement interventions, and revise Resident # 1's care plan for this behavior. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE], Resident # 1 was observed in Resident #3 bed unclothed. Resident # 3 was a vulnerable deaf, mute male Resident. The facility failed to investigate, implement interventions, and revise Resident #1's care plan for the behavior. On [DATE], at approximately 3:30 AM, the staff responded to the call light in Resident # 1's room, and he was observed unclothed and lying on top of Resident # 2. Licensed nurses and certified nursing assistants intervened. Resident # 2's body fell to the floor and cardiopulmonary resuscitation measures (CPR) were initiated. The emergency management services (EMS), and police department were notified. EMS arrived at the facility at approximately 3:50 AM. The emergency management services continued cardiopulmonary resuscitation measures until 4:12 AM and discontinued life resuscitating measures. The local police arrived at the facility at approximately 3:50 AM and interviewed Resident # 1, licensed nurses and certified nursing assistants (CNA). The local police took statements and confirmed Resident # 2 was deceased . The local coroner arrived to examine Resident # 2's body and removed the body from the facility with the understanding that an autopsy would be completed to determine the final cause of death. Corrective Actions: 1. On [DATE] Resident # 1 was placed on one-on- one (,d+[DATE]) supervision immediately. Psychiatric placement was initiated on [DATE] at approximately 8:00 am but was unsuccessful. A telehealth visit was conducted with the psychiatric nurse practitioner on [DATE] at approximately 12:00 PM. Resident #1 remained on ,d+[DATE] supervision until he was discharged to the custody of the local police department on [DATE] at 3:45 PM. 2. The Administrator presented to the facility on [DATE] at approximately 4:40 AM and initiated an investigation with assigned licensed nurses and certified nursing assistants. 3. On [DATE] The Administrator notified the MS State Department of Health at 5:50 AM, Attorney General Office at 9:00 PM and Ombudsman on [DATE] at 11:08 AM. 4. An in-service was initiated for all staff on [DATE] at approximately 5:30 AM regarding supervision of accidents and incidents, abuse/neglect, how to handle resident to resident altercations, reporting of any resident with delusional behaviors or verbalizing harmful behaviors to others, how to deal with aggressive behaviors. 5. A special resident council meeting was conducted on [DATE] 11:30 AM by the Administrator and Director of Nurses to ensure that the facility's residents felt safe. 21 out of 21 Residents verbalized feeling safe in the facility. 6. On [DATE] at approximately 3:30 PM, the social service department completed a 100% audit on roommate compatibility. 100% of the roommates were compatible or chose to be roommates. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. On [DATE] an in-service was initiated at approximately 10:00 am by the [NAME] President of Operations for all staff on prevention/supervision of accidents, abuse/neglect, abuse reporting, resident rights, implementing interventions to prevent reoccurrence and updating care plans to reflect interventions and monitoring of behaviors. In-service details: When residents are observed in another resident's bed to immediately intervene and separate. The staff was instructed to notify the nurse immediately and protect the alleged victim by remaining 1-on-1 supervision with the alleged aggressor. The nurses were instructed to immediately perform head to toe skin assessments for both Residents while ensuring and notifying the Executive Director and Director of Nurses. The Administrator and Director of Nurses were instructed to ensure that a thorough investigation is completed and reported to the state agencies. The Administrator and Director of Nurses was instructed to ensure that interventions are put in place to protect other Residents and the alleged aggressor's care plan is updated and behavior is monitoring is in place. In-service also included notifying the nurse, Administrator, and Director of nurses immediately if any Resident verbalize or exhibits delusional behaviors that are harmful towards others. No staff will be allowed to work until the in-service is received. 8. On [DATE] at 9:00 AM, the [NAME] President of Operations in serviced the Administrator and Director of Nurses at 9:00 AM on abuse/neglect and ensuring to investigate and report all instances of abuse/neglect to regulatory agencies. 9. On [DATE] at 10:15 AM, the [NAME] President of Operations in serviced the social service department on ensuring that care plans are revised to reflect interventions and behaviors are monitored. 10. On [DATE] at approximately 11:30 AM, an interview was initiated for 28 cognitive residents to determine if they have incurred any issues with other residents lying in their beds. 28 of 28 Residents denied any concerns. 11. A 100% audit was initiated on [DATE] at 1:30 PM by the social services department to ensure that all Residents had compatible roommates. No issues identified. 12. A 100% audit was conducted on [DATE] at 2:00 PM by the social services department to ensure that Residents' behaviors are care planned and monitoring is in place. 13. The Administrator reported the [DATE] incident involving Resident # 1 and Resident # 3 to the MS State Department of Health at 2:13 PM on [DATE]. 14. An emergency quality assurance committee met on [DATE] at 2:50 PM. The attendees of the meeting were the Administrator, Director of Nurses, Assistant Director of Nurses, Social Services Assistant, Staff Development Coordinator, Nurse Practitioner, Regional Clinical Operations Nurse, and Regional [NAME] President. The facility discussed the current survey IJ outcomes. 5 IJ cites for abuse/neglect, abuse reporting, revision of care plans, behavioral monitoring, and accidents/incidents. Upon investigation, Resident # 1 had previous behavioral issues on [DATE] with Resident # 3. Resident # 1 was unclothed. The facility failed to report, investigate and implement interventions based on the behaviors. In-services modified as of [DATE] to include protecting residents from others who get into their beds by intervening and providing 1-on-1 supervision. In addition, reporting and investigating alleged events. All policies were reviewed for accidents/incidents, abuse prevention, revision of care plans, behavioral monitoring. No changes required. 14. The Ombudsman was notified of the [DATE] on [DATE] at 3:27 PM by the Administrator. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255113	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruleville Nursing and Rehabilitation Center LLC	800 Stansel Dr Ruleville, MS 38771

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	15. The Administrator reported the [DATE] incident involving Resident # 1 and Resident # 3 to the Attorney General Office online system on [DATE] at 3:40 PM. Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of [DATE] and the Immediate Jeopardy was removed [DATE]. Validation: SA Validations were made onsite during the complaint investigation CI MS #25192. On [DATE], the SA surveyor verified through staff and resident interview, record review, sign-in sheets, and in-service reviews that all corrective actions had been taken by the facility to remove the IJ during the survey on [DATE] and the IJ was removed on [DATE].