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	06/25/2024

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 47158 Based on observation, staff interview, record review, and facility policy review the facility failed to prevent a resident from being physically restrained with a sheet tied to the wheelchair. The facility also failed to obtain physician orders, consent and failed to assess a resident for the need of restraints (mattress with elevated sides and wedges) for one (1) of six (6) residents reviewed. Resident #1. Findings included: Review of the facility policy titled, Restraint Evaluation & (and) Restraint Reduction, revised 12/23, revealed, Policy: as per OBRA (Omnibus Budget Reconciliation Act) requirements, all residents have the right to be unrestrained. Restraints should be used only as a last alternative and only when other less restrictive measures have been tried and rejected.Definition: Physical Restraints are defined as any manual method of physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access.Procedure: 2.) All residents using a restraint are to be evaluated utilizing the Restraint Evaluation Form.4.) A specific physician's order is to be entered in the resident's medical record which details the medical reason, type of restraint and when to be used . Record review of the facility occurrence, completed by the Director of Nursing (DON) revealed that an investigation was conducted on 6/10/24, when the DON was informed of a resident possibly having a sheet tied on her wheelchair the previous day. After staff interview which revealed four (4) CNAs stated they saw the resident restrained on 6/9/24 with a sheet tied around the wheelchair, the facility determined that because the resident was recently combative and sliding down in the chair; someone may have tied a sheet loosely around her wheelchair. An observation and interview on 6/25/24 at 8:30 AM, with Certified Nursing Assistant (CNA) #1 revealed Resident #1 was in bed on a mattress with elevated sides that extended the length of the mattress and four (4) - 18 by eight (8) inch foam wedges which were present on either side of her upper and lower body. CNA #1 verified that Resident #1 currently had a mattress with elevated sides and wedges in use in the bed to keep her off of the floor. She stated that the daily care guide lets her know what type of devices the resident should have. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Licensed Practical Nurse (LPN) #1 on 6/25/24 at 8:40 AM, stated that Resident #1 had a history of falls and that the mattress with elevated sides and wedges were to keep the resident from falling. She stated that she has to check the resident about every 30 minutes because she gets up unassisted. A record review of the facilities Daily Care Guide for Resident #1 revealed, under interventions Concave bed with elevated sides . There were no interventions listed for the use of foam wedges. A record review of the Physician's Order List for Resident #1 revealed no physician's orders for a mattress with elevated sides or wedges. Record review of a written statement on company letter head, provided by the Administrator, undated, revealed that the facility did not have physician's orders, consents or assessments for the mattress and wedges that were in place for Resident #1. In a telephone interview with CNA #3 on 6/25/24 at 9:00 AM, she stated when she came on duty a little after 7:00 AM on 6/9/24, she noticed Resident #1 had a sheet tied around her waist tied in a knot behind the wheelchair. She stated that she knew that the resident should not be restrained that way. CNA #3 stated that she brought it to the attention of the resident's nurse LPN #1. CNA #3 stated LPN #1 told her that it was to aid in the resident's safety and for her protection. During an interview with CNA #1 on 6/25/24 at 9:35 AM, she stated that on 6/9/24 after lunch, she saw Resident #1 tied in the wheelchair with a sheet. She stated that CNA #2 told her the nurse put it on. CNA #1 stated she and CNA #2 removed the sheet and showered the resident but did not reapply the sheet. In a telephone interview 6/25/24 at 10:40 AM, with CNA #2 she stated on 6/9/24 at 9:30 AM, while making rounds she saw Resident #1 sitting in the day room restrained in the wheelchair with a sheet with a knot tied in the back. She stated she untied the sheet to take the resident to her room to provide incontinent care. CNA #2 states that she left the sheet off of the resident but when she went to get Resident #1 after lunch, she was restrained with a sheet in the wheelchair again. She stated that one of her co-workers informed her that the nurse said it was for the resident's safety and not to remove it. CNA #2 stated that she and CNA #1 removed the sheet and showered the resident. She stated that they did not reapply the sheet. In an interview with LPN #1 on 6/25/24 at 10:45 AM, she verified that she was assigned to Resident #1 on 6/9/24. LPN #1 denied any knowledge of Resident #1 being restrained in the wheelchair with a sheet. She stated she did not see the resident restrained and she denied anyone bringing to her attention that the resident was restrained. LPN #1 denied restraining the resident or telling staff that it was for the resident's safety and protection. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 6/25/24 at 11:00 AM, she verified that based on her investigation it was likely that someone restrained Resident #1 in the wheelchair with a sheet on 6/9/24, because the resident had recently been combative and had slid down in the wheelchair. She stated that she was unable to determine who had restrained the resident. The DON stated that she felt that they had done it for the resident's safety and did not feel that the resident was at risk of any injuries related to being restrained in the wheelchair with a sheet. During further interview the DON verified that there were no wedges listed as interventions on Resident #1's Daily Care Guide and agreed that there were no physician's orders for the use of a mattress with elevated sides or wedges for Resident #1. During an interview with the Unit Manager (UM) on 6/25/24 at 1:16 PM, she revealed that a resident should never have any restraints applied without assessment , physicians' orders, and family consent. She stated restraining a resident places the resident at risk of sliding in the chair and getting choked. Record review of the Face Sheet revealed the facility admitted Resident #1 on 5/6/2024, with diagnoses that include Dementia and Impulse Disorder.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 47158 Based on staff interview, record review and facility policy review the facility failed to report an allegation of mistreatment when a resident was physically restrained with a sheet tied to the wheelchair for one (1) of six (6) residents reviewed. Resident #1. Findings Included: Review of the facility policy titled, Abuse Prevention, revealed the definition of mistreatment means inappropriate treatment of a resident. All alleged violations involving abuse, neglect, exploitation, or mistreatment are reported immediately, but no later than two hours after the allegation is made. Record review of the facility occurrence, completed by the Director of Nursing (DON) revealed that an investigation was conducted on 6/10/24, when the DON was informed of a resident possibly having a sheet tied on her wheelchair the previous day. After staff interview which revealed four (4) Certified Nursing Assistants (CNAs) stated they saw the resident restrained on 6/9/24 with a sheet tied around the wheelchair, the facility determined that because the resident was recently combative and sliding down in the chair; someone may have tied a sheet loosely around her wheelchair. On 6/25/24 at 10:40 AM, a telephone interview with Certified Nursing Assistant (CNA) #2 she stated on 6/9/24 at 9:30 AM, while making rounds she saw Resident #1 sitting in the day room restrained in the wheelchair with a sheet tied in a knot. She states that she took the sheet off of the resident but when she went to shower Resident #1 after lunch, she was restrained with a sheet in the wheelchair again. She stated that one of her co-workers informed her that the nurse said it was for the resident's safety and not to remove it. During an interview with the DON 6/25/24 at 11:45 AM, she stated that the facility did not report the allegation of the resident being restrained in the wheelchair with a sheet because they ran it up the flagpole with corporate and determined that the occurrence did not need to be reported to the State Agency because she knew that it was done for the resident's safety due to her behaviors and falls. She stated the facility was unable to determine who had restrained the resident with a sheet in the wheelchair. In an interview with the Administrator on 6/25/24 at 2:00 PM, he agreed that the use of a sheet to restrain a resident in the wheelchair was an inappropriate treatment to prevent falls, therefore, mistreatment and should have been reported to the State Agency. Record review of the Face Sheet revealed the facility admitted Resident #1 on 5/6/2024, with diagnoses that include Dementia and Impulse Disorder. Record review of an annual Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 5/13/24 revealed under section GG that Resident #1 was dependent for locomotion in the wheelchair.