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	08/27/2025

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on staff and resident interview, record review and facility policy review, the facility failed to resolve a grievance for one (1) of eight (8) residents present at the resident council meeting. (Anonymous Resident). Findings IncludeReview of the facility policy titled Grievance/Missing Property with a revision date of 8/17 revealed under Purpose .to provide an opportunity for residents, resident representatives and/or family to present concerns or grievance to the proper authorities at the facility and to receive responses to the issue(s) raised. Under Procedure .A.3 .Supervisory personnel shall be responsible for notifying the resident of resolution and so indicate on grievance form .An interview on 8/25/25 at 10:15 AM, Anonymous Resident complained that Certified Nursing Assistant (CNA) #6 jerked his legs when she turned him and it hurt his back. He admitted that he reported this to the staff, but no one had come to ask him about it.An interview and record review on 8/25/25 at 4:00 PM with the Director of Nurses (DON) confirmed that the Anonymous Resident had complained about CNA #6 and she had filled out a grievance form for him. Record review of the grievance that was completed for the Anonymous Resident revealed that the resident had not signed the grievance form and there was no documentation that the grievance had been resolved or discussed with the resident and DON confirmed.Record review of the grievance log revealed a grievance from Anonymous Resident regarding CNA #6 hurting him when they jerked his turn pad but was listed as a complaint regarding customer service and was marked as resolved.An interview with Social Services #2 confirmed that all grievances should be discussed with the residents and signed by the residents before they can be considered resolved.

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

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	08/27/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review, and facility policy review, the facility failed to ensure that all alleged abuse violations were reported to the State Survey Agency as required. This deficient practice had the potential to place residents at risk for abuse and/or neglect. For three (3) of the five (5) alleged abuse violations reviewed. Resident #3, Anonymous Resident, and Resident #68. Findings Include Review of the facility policy titled: “Abuse Prevention” dated 10/22, revealed, “The facility is committed to protecting the residents from abuse by anyone, including, but not necessarily limited to: facility staff… under Reporting: Alleged violations involving abuse, neglect, …are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including State Survey Agency…) Under Corrective Action: Any instances of employee disregard for the policies and procedures of this facility are cause for corrective action up to and including suspension, termination, and reporting to licensing agencies.” Resident #3 A record review of a written statement dated 2/14/25 and signed by Certified Nurse Aide (CNA) #1 revealed, “I, (proper name of CNA #1) was working with Resident #3 on Friday, [DATE]. We put her in the bed, and she went to crying and I asked her what was wrong, and she said her legs were hurting and I just said your legs ain’t hurting, she told me to shut up and I said you shut up.” An interview with Resident #3 on 8/25/2025 at 11:10 AM, she stated, “Certified Nurse Aide (CNA) #1 told me to shut up when I complained about my legs hurting when she put me to bed. I told her I would report her, and she said she didn’t care who I told about it.” She revealed she told the former Administrator about it.” An interview with the Former Administrator on 8/26/25 at 2:40 PM confirmed that Resident #3 had reported that CNA #1 had told her to shut up when she complained of leg pain during repositioning. The former administrator revealed that she had immediately sent CNA #1 home and started her investigation. She confirmed she did not report it to the State Survey Agency because she didn’t see that it was abuse, because by Monday, when I returned to work to talk with Resident #3, she said it was okay, but that she didn’t want CNA #1 to take care of her anymore. She revealed she took CNA #1 off the schedule for a couple of days, did corrective counseling with her, and allowed her to return to work. Record review of the “admission Record” revealed Resident #3 was admitted to the facility on [DATE] with diagnoses that included Major Depressive Disorder, Anxiety Disorder, Pain, and Cerebral Palsy. (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	08/27/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of June 5, 2025, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, which indicates that Resident #3 is cognitively intact. Anonymous Resident An interview with Anonymous Resident on 8/25/25 at 10:15 AM revealed that he had reported that Certified Nurse Assistant (CNA) #6 and CNA #2 had hurt him during care. He stated that CNA #6 jerked his legs and hurt his back when she turned him and that CNA #2 slapped him in the face with a wet towel when she was bathing him. He admits that no one ever came and talked to him about it, but that neither CNA has returned to his room. An interview on 8/26/25 at 2:30 PM with CNA #6 revealed she recalls the day that the Anonymous Resident complained that they hurt him when they turned him and she was told not to go back to his room. Record review of Anonymous Resident’s “admission Record” revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Paraplegia. Record review of Anonymous Resident’s MDS with an ARD of 7/14/25 revealed in Section C, a BIMS score of 15, indicating that the resident was cognitively intact. Resident #68 An interview on 8/25/25 at 11:00AM with Resident #68 revealed that he reported to the Director of Nurses (DON) that he did not want CNA #2 back in his room. He stated that she hurts him when she tries to turn him and sometimes, she talks ugly to him. He admitted CNA #2 does not come to his room anymore, but that no one had questioned him about why he didn’t want her in his room anymore. A phone interview on 8/26/25 at 3:15PM with CNA #2 recalled that Anonymous Resident complained that she had wiped his bottom too hard when she was cleaning him, so they told her not to go back in his room. She revealed that last week she was told not to go back into Resident #68’s room but was not told why and today she was suspended while they investigated this with Resident #68. Record review of Resident #68’s “admission Record” revealed the resident was admitted on [DATE] with medical diagnoses that included Anxiety, Pain and Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side. Record review of Resident #68's MDS with an ARD of 7/17/25 revealed in Section C a BIMS score of 14, which indicates the resident is cognitively intact. An interview on 8/25/25 at 4:00PM with the DON confirmed that she had a complaint on CNA #2 for Resident #68 and CNA #6 for an Anonymous Resident but admitted that she felt like it was more of a customer service issue and therefore did not report it to the state. She confirmed that she removed both CNA’s from providing care to these residents and should have reported the allegations to the state. (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	08/27/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 8/26/25 at 9:30AM with the ADM confirmed that all allegations of abuse should be reported to the state. She stated she was aware of some complaints on CNA #2 but was not aware of any abuse allegations since she had been here and she started in April 2025.

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	08/27/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interviews, record review and facility policy review the facility failed to investigate allegations of abuse for two (2) of five (5) residents reviewed for abuse. Residents #68 and Anonymous Resident Findings IncludeReview of the facility policy titled, with a revision date of 10/22 revealed under Investigate: .the facility will initiate at the time of any finding of potential abuse or neglect an investigation to determine cause and effect, and provide protection to any alleged victims to prevent harm during the continuance of the investigation.An interview on 8/25/25 at 10:15AM with an Anonymous Resident revealed that Certified Nurse Assistant (CNA) #6 and CNA #7 came in to turn him and they jerked his legs and hurt his back. He admitted that he reported it to staff that he thought it was CNA #6 and admits that she hasn't worked with him since. He then stated that he reported to the Administrator that CNA #2 was giving him a bed bath and when he ask her to wash his back, she wet the towel and slapped his face with it as she was reaching over him. He admitted that she had not worked with him since, but that no one had come and talked with him about either report.An interview on 8/25/25 at 11:00AM with Resident #68 revealed that CNA #2 tries to turn him every day by herself. He stated that it needs to be two people because it hurts and sometimes, she talks ugly to him. He admitted that he reported CNA #2 to the Director of Nurses (DON) and now CNA #2 does not come to his room anymore, but that no one had come and questioned him about it.An interview on 8/25/25 at 11:40AM with the DON confirmed that there was a resident that complained about CNA #6 and that Resident #68 had complained about CNA #2 and she had removed them from those resident's care but had not completed an investigation.An interview on 8/25/25 at 2:30PM with CNA #7 confirmed that she was present and assisted CNA #6 on the Anonymous Resident the day he complained that we had hurt him. She stated that they did not feel like they did anything wrong or different, but they reported it to the DON.A follow-up interview on 8/25/25 at 4:00PM with the DON confirmed that she had a complaint on CNA #2 for Resident #68 and CNA #6 for an Anonymous Resident, but admitted that she had not done an investigation, because she felt like it was more of a customer service issue and therefore did not report it to the state. She confirmed that she removed both CNA's from providing care to these residents. She stated that a couple of days after the Anonymous Resident complained on CNA #6, the resident was sent to the emergency room for back pain and admits that an investigation should have been completed. She revealed she would start an investigation now. She stated she does not recall having any complaints from the Anonymous Resident regarding CNA #2.An interview on 8/26/25 at 9:30AM with the ADM confirmed that all allegations of abuse should be investigated. She stated she was aware of some complaints on CNA #2 but was not aware of any abuse allegations since she had been here and she started in April 2025.An interview on 8/26/25 at 2:30PM with CNA #6 revealed she recalls the day that the Anonymous Resident complained that they hurt him when they turned him and she was told not to go back to his room.A phone interview on 8/26/25 at 3:15PM with CNA #2 recalled that Anonymous Resident complained that she had wiped his bottom too hard when she was cleaning him, so they told her not to go back in his room. She revealed that last week she was told not to go back into Resident #68's room but was not told why and today she was suspended while they investigated this with Resident #68. Record review of Anonymous Resident's admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Paraplegia.Record review of Anonymous Resident's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/14/25 revealed in Section C, a Brief Interview for Mental Status (BIMS) score of 15, indicating that the resident was cognitively intact.Record review of Resident #68's admission Record revealed the resident was admitted on [DATE] with medical diagnoses that included Anxiety, Pain and Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side.