STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255228	A. BUILDING _____ B. WING _____	06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA REHABILITATION AND HEALTHCARE CENTER	200 DR MARTIN LUTHER KING JR DRIVE CLEVELAND, MS 38732

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Survey Agency (SA) conducted an annual recertification survey at the facility from 6/24/19 to 6/27/19. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited the regulatory deficiencies F641 and F812. At the time of the survey, the census was 72, and the facility held a license for 75 beds.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to accurately complete a Minimum Data Set Assessment (MDS) for wandering behavior, for one (1) of 18 MDS assessments reviewed, Resident #22. Findings include: Review of a facility's policy statement , dated June 27, 2019, "Delta Rehabilitation and Healthcare Center of Cleveland does not have a Minimum Data Set (MDS) policy, we utilize the Resident Assessment Instrument (RAI) manual". Review of Center's for Medicare Service's (CMS) RAI Version 3.0 Manual (October 2017), Section E 0900: Wandering...Wandering is the act of moving (walking or locomotion in a wheelchair)	F 641	Preparation and submission of the plan of correction by Delta Rehabilitation and Healthcare, does not constitute an admission or agreement to the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws. 1. On 7/3/19, Resident #22's Minimum Data Set (MDS) five (5) day/annual was modified and submitted to show accurate coding for wandering by the MDS Nurse. 2. On 7/10/19, an audit was conducted by Social Services Director and MDS Nurse by reviewing six (6) residents identified	7/15/19

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

Electronically Signed | 07/19/2019

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F 641	Continued From page 1 from place to place with or without a specified course or known direction. Wandering may or may not be aimless. The wandering resident may be oblivious to his or her physical or safety needs. The resident may have a purpose such as searching to find something, but he or she persists without knowing the exact direction or location of the object, person or place. Review of the Annual MDS, Section E, with an Assessment Reference Date (ARD) of 4/19/19, revealed Item E 0900 is marked "0", which indicated "Behavior not exhibited" for wandering. On 06/26/19, at 8:46 AM, Resident #22 was observed wandering down A wing hall, where she tried to follow a nurse into a room. The nurse redirected the resident, who turned around and walked the other way. On 06/26/19, at 9:20 AM, an observation of Resident #22, in the common room during "Inspiration" activity, revealed that she was continuously walking aimlessly around the perimeter of the area throughout the meeting. Resident #22 was observed throughout the survey wandering in hallways and into the common area and dining room aimlessly . A "Wander Guard" device was in place to the right wrist. Interview with the Director of Nursing (DON) and the Administrator, on 6/26/19, at 10:00 AM, revealed that Resident#22 wanders daily, aimlessly, but does not try to exit. The DON stated that "wandering" should have been marked on the MDS; this is a behavior she exhibits daily and probably staff do not think of it as abnormal for her. The DON stated the Social Services Director (SSD), is responsible for completing Section E of the MDS, and she is on vacation.	F 641	with wandering behaviors MDS's submitted in the last three (3) months to ensure accurate coding of MDS related to wandering; seven (7) MDS assessments were modified and resubmitted. 3. In-servicing with the Social Services Director was conducted on 7/3/19 by the MDS Nurse on accurately coding wandering/behaviors on the MDS from the Resident Assessment Instrument (RAI) manual. In-servicing with the MDS Nurse and Interdisciplinary Team was conducted on 7/15/19 by the Clinical Reimbursement Specialist on MDS coding accuracy from the Resident Assessment Instrument (RAI) manual. 4. Beginning the week of 7/15/19, the Social Service Director and MDS Nurse will conduct three (3) audits weekly to ensure MDS's are accurately coded as related to wandering for four (4) weeks and monthly for two (2) months and quarterly thereafter. A report will be submitted to the Quality Assurance Performance Improvement Committee for three (3) months by the Director of Nursing (DON)/Administrator for review and further recommendation. The Administrator is responsible for ongoing monitoring and overall compliance.	

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F 641	Continued From page 2 During an interview on 6/26/19 at 10:30 AM, Licensed Practical Nurse #1/Minimum Data Set Nurse stated, "It's a normal behavior for her, wandering, she walks non-stop, even in the dining room she'll get up and down, she just walks. I understand there is a question about Social Services not claiming it on the MDS. I need to do education in regards to that. I will have the Social Worker do an addendum to correct that when she gets back. It should have been coded. I'm going to have to do some education. They think of it as her normal behavior but wandering should have been coded, yes". During an interview on 6/27/19 at 10:17 AM, Registered Nurse #1, (RN)/Staff Development stated, "She has always walked the halls since she's been here. She recently started going toward the doors and that's when we decided to evaluate her for wandering. The 'wanderguard' was placed 3/25/19." Review of the Admission Record for Resident #22 revealed the facility admitted the resident on 5/16/07, with diagnoses to include but not limited to Alzheimer's Disease and Schizophrenia. Record review of the Order Summary Report for Resident #22, dated 6/26/19, revealed that Resident #22 had an original order dated 3/25/19, for "Wander Bracelet related to wandering/exit seeking behaviors". Record review of the current care plan, revised 4/22/19, for Resident #22 revealed, "Focus: I have been evaluated as a wandering risk related to decreased safety awareness, confusion, wandering behavior. Resident at times follows	F 641		

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F 641	Continued From page 3 staff around and will follow to door although not exit...Wander guard in place due to increased wandering, pacing around facility, in and out of residents room".	F 641		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to ensure milk products were disposed of when expired for one (1) of two (2) tours of the kitchen. Findings include: Review of the facility's document titled, "Receiving", dated 9/2017, revealed a Policy Statement that safe food handling procedures for	F 812	1. On 6/24/19, Dietary Aide #1 threw away the expired twenty-six (26) one half (1/2) pint cartons of reduced fat milk. Dietary Manager #2 conducted an audit of labeling and dating of food; no other expired items found. On 6/24/19 the Dietary Aide #1 was in-serviced on monitoring milk delivery and daily monitoring of expiration dates by the District Dietary Manager.	7/15/19

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F 812	Continued From page 4 time and temperature control will be practiced in the transportation, delivery, and subsequent storage of all food items. On 06/24/19 at 10:20 AM, an observation of the kitchen in the initial tour with Dietary Aide #1 (the Dietary Manager was not available during the survey) revealed the milk cooler (which was located in the main kitchen against the left wall as you enter the kitchen) contained 26 one half (1/2) pint cartons of reduced fat milk, with expiration dates of 6/17/19. On 06/24/19 at 10:40 AM, an interview with Dietary Aide #1 confirmed 26 cartons of reduced fat milk had dates of 6/17/19, and were in the milk cooler. Dietary Aide #1 revealed that all dietary staff are responsible for making sure there is no expired food products available to staff to be used for residents. Dietary Aid #1 revealed that if a resident drank an expired carton of milk, it could make them sick. The Dietary Aide revealed she was going to throw away all of the expired milk. On 6/25/19 at 10:45 AM, an interview with the Administrator revealed she was told by Dietary staff there was expired milk in the cooler in the kitchen, and they threw out the expired milk.	F 812	2. On 6/25/19 & 6/28/19, District Dietary Manager conducted and audit of food items in regards to expiration dates; no issues were identified. Residents who drink milk from the dietary department are at potential risk associated with this deficient practice. 3. On 6/24/19 and 7/10/19, Dietary Staff was in-serviced on Food Storage Policy, monitoring milk delivery and daily monitoring of expiration dates by the District Dietary Manager. 4. Beginning the week of 7/1/19, the Dietary Manager and Administrator will conduct five (5) audits a week for expired milk for four (4) weeks, then weekly for four (4) weeks, monthly for two (2) months and quarterly thereafter. The Dietary Manager will submit a report to the Quality Assurance Performance Improvement Manager for review and further recommendation. The Administrator is responsible for ongoing monitoring and overall compliance.	

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	255228	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/27/2019**

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K 000	INITIAL COMMENTS 42 CFR 483.70 (a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 06/27/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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