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 _____	C 05/27/2022

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**

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F 000	INITIAL COMMENTS The State Agency (SA) conducted two Complaint Investigations (CI MS #18793 and CI MS #18204) along with a COVID-19 Staff Vaccine Survey on 5/26/22 through 5/27/22. The facility was found to be in compliance with Infection Control Regulations related to COVID 19 Employee/Staff vaccines and has implemented the Centers for Medicare and Medicaid (CMS) and the Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19 staff vaccination or exemption status. The facility was found to not be incompliance with the regulations for the Center for Medicare and Medicaid for Misappropriation of Property. CI#18793 was substantiated with a deficiency cited for F602 at a D level. This was a facility reported incident. CI#18204 was unsubstantiated with no deficiencies cited for allegations of Improper Infection Control, Quality of Care/treatment/care not received as per MD orders, Resident Assessment and Neglect. The facility is licensed for 75 beds with a census of 63 at the time of survey.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, interview and	F 602	Preparation and submission of this plan	5/30/22

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

Electronically Signed | 06/15/2022

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F 602	Continued From page 1 policy/procedure review, the facility failed to ensure residents did not experience Misappropriation of property for one (1) of four (4) residents reviewed for Misappropriate of Property as evidenced by LPN #1 admitted to taking medication of Resident #1 for her own use. Interview with the Attorney General of Medicaid Fraud Unit Investigator, on 5/26/22 at 10:43 AM revealed he has interviewed the Licensed Practical Nurse (LPN) #1. He stated she did admit to taking the medications from Resident #1. "The facility has contacted the Mississippi Board of Nursing." He stated he intends to interview LPN #1 again to see if she will eventually confess to taking the medication from Resident #2. Interview with the Administrator 5/27/22 at 11:35 AM revealed that even though the Xanax for Resident #2 had been discontinued the pharmacy billed the facility for the prescription instead of Resident #2's insurance. The Administrator revealed she doesn't know when the Xanax disappeared because the numbers were changed on the Narcotic inventory card. LPN #1 is the only one that changed the number of narcotic cards on the narcotic control sheet count. The facility did a match back on both units of all narcotics. The administrator revealed that the pharmacy sent the facility a list of monthly narcotics dispensed for March and April 2022. The facility was doing a match back to account for all of the narcotic cards. Interview with the Pharmacist on 5/27/22 at 12:20 PM, revealed on 5/3/22 the pharmacy sent 89 Ativan 1 MG to the nursing home for Resident #1. The Pharmacist stated the pharmacy sent replacement pills to the backup pharmacy to	F 602	of correction by Delta Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of truth of the facts alleged or the correctness of the conclusion set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirement under the state and federal laws. 1. On May 3, 2022, medications were replaced by the facility for two (2) of twenty-two (22) residents reviewed. Resident #1 Ativan 1 mg was replaced by National Pharmacy. Resident #1 received medication as prescribed by the physician. Resident #2 Zanax was billed to the facility. LPN (Licensed Practical Nurse) #1 was suspended on May 3, 2022 and terminated on May 25, 2022. 2. Twenty-two (22) Residents that receive narcotics from February 15, 2022 to May 3, 2022, had the potential to be affected. On May 4, 2022 and May 5, 2022, Medical Records Supervisor audited all narcotics received in the last sixty (60) days to ensure medication and/or control drug log was accounted for; two (2) residents that were identified as being affected of misappropriation, were billed to the facility. 3. In-services on Abuse and Neglect, Residents Rights, Vulnerable Adults Act, Misappropriation, and Shift Change Control Substance Inventory Log was initiated on May 4, 2022, by Staff Development Coordinator (SDC) with the nursing staff. 4. On May 5, 2022, Quality Assurance	

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F 602	Continued From page 2 cover the doses the back up pharmacy provided for Resident #1 and Resident #2 so there would not be any missed doses of medications. He stated the facility has been billed for the missing medications. Record review of an email sent 5/27/22 at 12:39 PM by the pharmacist revealed the billing transaction with the facility to prove the facility has been billed for the missing medications. Interview with LPN #3 on 5/26/22 at 3:15 PM revealed she was the nurse that realized there was a missing card of Ativan for Resident #1 during morning narcotic count with the off going nurse. LPN #3 revealed she was just coming back from four (4) days off work. LPN #3 stated she did her rounds and noticed that Resident #1 had returned from Geri psych. When she did the narcotic count, it appeared normal. She had the correct number of cards and the pill count was correct. Resident #1 gets a 9:00 AM Ativan and there was no Ativan card for her. Yes, there was Ativan when she last worked. but could not recall how many cards, maybe two (2). The Director of Nurses (DON) came down the hall and I let her know the Ativan for Resident #1 was not in the medication cart. LPN #3 had counted the narcotic medications with an agency nurse. The DON told LPN #3 to see where the old Ativan medication cards were and was there was Ativan when she last worked. She began her investigation and I went on with my day. I got the doses of Ativan needed for Resident #1 out of the Emergency Drug Kit (EDK)." Interview with LPN #2 at 3:30 PM on 5/26/22 revealed that she went into the EDK box with LPN #1 to get the Ativan required for Resident #1.	F 602	Performance Improvement Committee was held to review concern and audits no changes at this time. Beginning the week of May 9, 2022, the Registered Nurse Supervisor (RN) will conduct audits three (3) times a week to ensure narcotic count and control drug log is accurate weekly for four (4) weeks, then monthly for two (2) months, then quarterly thereafter. A report will be submitted monthly to the Quality Assurance Performance Improvement Committee by the Administrator for further recommendations. The Administrator is responsible for on-going monitoring and compliance. Any changes or revisions deemed necessary after review for monitoring/compliance will be initiated through Quality Assurance Performance Improvement Committee.	

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LPN #2 revealed Resident #1 did not miss a dose of her Ativan. Record review of the MAR and the MD orders confirmed that Resident #1 did not miss a dose of Ativan.

Interview with LPN #2 at 11:00 AM on 5/27/22 revealed that Resident #1 had returned to the facility on 5/2/22 in the late afternoon. She received her Ativan doses while at Geri Psych that day. The medical doctor (MD) had continued the same order of Ativan, 1 MG three times a day (TID), upon facility return. LPN #2 stated "She got an IM Ativan on 5/3/22 when the PO meds could not be found." LPN #2 revealed that the Medication Administration Record (MAR) has a "5" on the 5/3/22 morning dose because the Ativan was given as an intramuscular (IM) instead of by mouth (PO). She stated that the pharmacy was contacted when the Ativan could not be found. It is required the pharmacy sends a code to open the EDK box. LPN #2 stated "there was no harm or change to the resident."

Attempted interviews with LPN #1 on 5/26/22 at 11:00 AM and on 5/27/22 at 1:45 PM were unsuccessful. There was no voicemail setup to leave a message.

Observation of narcotic count at the end of 7-3 shift on 5/26/22 at 3:00 PM with LPN #1 and oncoming LPN revealed no issues. The correct number of cards and correct numbers of medications were noted.

Observation of a random mid-shift narcotic count on 7-3 shift on 5/27/22 at 12:00 PM with LPN Alisha Sellers and LPN Melissa King for B wing narcotics. There were no issues noted. The correct number of cards and narcotic medication

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count were observed.

Observation and interview with Resident #1 on 5/26/22 at 10:29 AM revealed resident in bed. She is dressed and groomed well. The bed is in the lowest position with a mattress on the floor beside the bed. She did not awaken when her name was called.

Record review of Resident #1 face sheet on 5/26/22 revealed that her diagnosis are Dementia in other diseases classified elsewhere with behavioral disturbances, Altered mental status unspecified, Unspecified psychosis not due to a substance or known physiological condition and Anxiety disorder.

Observation and interview with Resident #2 on 5/26/22 at 10:34 AM revealed she was sitting on the side of her bed. She was dressed and groomed well. When asked about her medications she stated she "guesses" she take them correctly. "I just take what they give me."

Policy and Procedure review on 5/26/22 of the facility's "Abuse Prohibition Policy" last revised "12/12/19" revealed that the intent of the policy is "This protocol was intended to assist in the prevention of abuse, neglect and misappropriation of property. Each resident has the right to be free from abuse, mistreatment, neglect, corporal punishment, involuntary seclusion and financial abuse." The policy states "1. The facility will prohibit neglect, mental or physical abuse, including involuntary seclusion and the misappropriation of property or finances of residents". The policy includes a definition for "Misappropriation of property/financial abuse/Exploitation is defined as taking advantage

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F 602	Continued From page 5 of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion." Record review on 5/27/22 of an in-service given on 3/17/22 revealed that LPN #1 was recently in-serviced on medication administration and how to count narcotics.	F 602		