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	02/12/2025

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

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 47158 Based on staff interviews, record reviews, and facility policy reviews, the facility failed to ensure that a resident was free from significant medication errors when Licensed Practical Nurse (LPN) #1 failed to administer prescribed antianxiety medications for one (1) of four (4) residents reviewed for medication administration. Resident #1. Based on interviews and record reviews the State Agency (SA) determined that all corrective actions had been implemented as of 11/14/24 and the facility was in compliance on 11/15/24, prior to the SA entrance on 2/12/25. This was cited as Past Non-Compliance. Findings Include: A record review of the facility policy titled Administering Medications with a revision date of April 2019 revealed Medications are administered in a safe and timely manner and as prescribed .22. The individual administering the medication initials the resident's Medication Administrator Record (MAR) on the appropriate line after giving each medication and before administering the next ones . A review of the facility investigation dated 11/15/24 revealed that on 11/13/24, the Director of Nursing (DON) noticed that despite a recent increase in Resident #1's antianxiety medication, there was no improvement in her outbursts. Upon conducting an audit of Resident #1's narcotic control log, the DON discovered that LPN #1 had failed to administer a scheduled narcotic to Resident #1 during the 3:00 PM-11:00 PM shift. LPN #1 was immediately suspended, and the Medical Director was notified. Corrective actions included: The DON completed a 100% audit of all residents receiving scheduled narcotics. LPN #1 completed Medication Error Reports on the missed doses for Resident #1 and notified the Family Nurse Practitioner (FNP). The Pharmacy Consultant was notified. The Social Services Director (SSD) conducted Life Satisfaction Surveys for residents with a Brief Interview for Mental Status (BIMS) score of 12 or higher regarding missed medications. Record review of a written statement dated 11/14/24 and signed by LPN #2 revealed that during a previous shift, when counting narcotics with LPN #1, she noticed that Resident #1's narcotic was signed out of the narcotic book but had not been administered. LPN #1 then popped the narcotic from the medication card and wasted it, stating she must have forgotten. Record review of a separate statement dated 11/13/24 and signed by LPN #1 revealed The medications were not signed out but were charted as given. This was a sincere mistake. I thought I was giving all of the medications but was not . I mentally thought I was administering all their medications. (continued on next page)

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #1's November 2024 MAR revealed an order for Klonopin Oral Tablet 0.5 mg via PEG tube two (2) times a day, with a stop date of 11/8/24. The medication was signed off as given by LPN #1 at 10:00 PM on 11/1/24, 11/4/24, 11/6/24, and 11/7/24. A further review of Resident #1's November 2024 MAR revealed Klonopin Oral Tablet 0.5 mg (milligrams) via PEG (percutaneous endoscopic gastrostomy) tube three (3) times a day for Anxiety Disorder, with a start date of 11/8/24. The medication was signed off as given by LPN #1 at 2:00 PM on 11/9/24 and 11/10/24; and at 10:00 PM on 11/8/24, 11/9/24, and 11/12/24. A review of Resident #1's Controlled Drug Record for Klonopin Oral Tablet 0.5 mg revealed that LPN #1 had not signed out any medication for the dates and times she documented as administered. Record review of the Medication Error Report dated 11/13/24 and signed by LPN #1 confirmed that Klonopin 0.5 mg was not administered for all the dates listed above. Under comments, LPN #1 wrote: Forgot to give with other medications. During an interview with the Administrator (ADM) and DON on 2/12/25 at 9:35 AM, they confirmed that their investigation revealed LPN #1 had failed to administer Klonopin 0.5 mg on nine (9) occasions during November 2024. They verified that Resident #1's Resident Representative, Medical Director, Pharmacy Consultant, the State Agency (SA), Attorney General, and Board of Nursing were notified on 11/13/24. Resident #1 was assessed by the FNP on 11/14/24, with no negative outcomes reported and no changes made to the care plan. They verified that the facility implemented corrective actions, including an in-service training initiated on 11/14/24 covering Medication Administration, Abuse/Neglect, Vulnerable Adults, and Resident Rights; training continued until all nurses completed the in-service. The Pharmacy Consultant observed medication administration for all nurses. The incident and investigation results were reviewed during the Quality Assurance and Performance Improvement (QAPI) committee meeting on 11/14/24. During an interview with the ADM on 2/12/25 at 10:20 AM, she verified that LPN #1 was terminated on 11/13/24. Record review of the Admission Record revealed the facility admitted Resident #1 on 2/26/24 with diagnoses which included Anxiety Disorder. Validation: On 2/12/25, the SA validated through interviews and record reviews that all corrective actions had been implemented as of 11/14/24. The facility began monitoring narcotic medication administration records by the DON daily times five weeks, then six residents' weekly times three months, then monthly thereafter. QAPI will review the findings of the monitoring monthly ongoing. The facility was determined to be in compliance as of 11/15/24, prior to the SA's entrance on 2/12/25.