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	07/31/2025

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on staff interview, record review, and Payroll-Based Journal (PBJ) staffing data review, the facility failed to submit PBJ data accurately to the Centers for Medicare and Medicaid Services (CMS) for one (1) of four (4) quarters reviewed. 2nd Quarter, 2025 (January 1 through March 31, 2025) Findings Include: Review of the typed statement on facility letterhead dated 7/30/25 and signed by the Administrator (ADM) revealed that the facility did not have a policy on PBJ submission. Record review of the “PBJ Staffing Data Report” revealed the facility triggered for excessively low weekend staffing for the 2nd quarter, 2025 (January 1 through March 31, 2025). During an interview with the ADM on 7/31/25 at 9:00 AM, she acknowledged that the corporate office was responsible for submitting the PBJ information. She confirmed that administrative staffing hours were not included in the data submitted, which contributed to the inaccurate representation of staffing levels.

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility failed to ensure a Discharge Minimum Data Set (MDS) was completed and transmitted within the required timeframes in accordance with the Resident Assessment Instrument (RAI) Manual for one (1) of 21 residents reviewed for MDS assessments. (Resident #58) Findings include: Review of a typed statement on facility letterhead dated 7/30/25 revealed the facility does not have a policy on MDS completion. The statement further indicated that the interdisciplinary team follows the RAI manual. Record review of the Discharge MDS for Resident #58 revealed the assessment was not completed or transmitted within the timeframes outlined in the RAI User’s Manual. Further review of the assessment revealed Resident #58’s discharge occurred on 7/1/25, but the MDS was not completed and/or transmitted, which exceeded the required 14-day timeframe. Section Z0500B (completion date) of the MDS was left unsigned. Review of the RAI Manual, Chapter 2, Section 2.7, revealed a Discharge assessment is required when a resident is discharged from the facility. The assessment must be completed (MDS Item Z0500B) within 14 days after the resident’s discharge date and electronically transmitted within 14 days of the assessment's completion date. During a phone interview with the Regional Case Mix Coordinator on 7/30/25 at 12:29 PM, she confirmed that after reviewing the Discharge MDS Assessment for Resident #58, the assessment was not completed or transmitted according to the RAI Manual. She stated that the purpose of completing and transmitting the MDS within the timelines outlined in the manual is to ensure an accurate depiction of the residents’ status during their stay in the facility. Record review of the “admission Record” for Resident #58 revealed the resident was admitted on [DATE] with diagnoses including Type 2 Diabetes with Hyperglycemia.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on staff interview and record review, the facility failed to accurately complete section N of the Minimum Data Set (MDS) for a resident taking anticoagulant medication for one (1) of five (5) residents reviewed for unnecessary medications. Resident #3 Findings include: Review of the typed statement on facility letterhead read, “(Proper name of the facility) does not have a policy on MDS completion. (Proper Name of the facility's) Interdisciplinary Team follows the RAI (Resident Assessment Instrument) manual.” Record review of Resident #3’s June 2025 Medication Administration Record (MAR) revealed an order dated 3/1/25, “Rivaroxaban (blood thinner) oral tablet 10 mg (milligrams) Give 10 mg (milligrams) via PEG (Percutaneous Endoscopic Gastrostomy) tube in the morning,” which was initialed as administered for all days in June. Record review of the Quarterly MDS with an Assessment Reference Date (ARD) of 6/26/25 revealed under Section N, Resident #3 was documented as not taking an anticoagulant medication. A telephone interview with the Regional Case Mix Manager on 7/30/25 at 12:21 PM confirmed that Resident #3’s MDS was not coded correctly to reflect the anticoagulant medication rivaroxaban. She stated, “We want the MDS to give us an accurate representation of that resident during the lookback period.” Record review of the “admission Record” revealed the facility admitted Resident #3 on 2/26/24 with a medical diagnosis of “Unspecified Dementia with Other Behavior Disturbance.” Record review of the Quarterly MDS)with an ARD of 6/26/25 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 3, indicating Resident #3 was severely cognitively impaired.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, record review, and facility policy review, the facility failed to develop a comprehensive care plan for one (1) of the twenty-one resident care plans reviewed. (Resident #36). Findings Include Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered with review date January 2023, revealed, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . On 7/29/2025 at 11:34 AM during an observation and interview with Resident #36, it was noted that the resident had dark facial hair on her upper lip, approximately one-fourth of an inch long, along with sparce hair on her chin. The resident expressed a desire for more frequent shaving, stating, They usually shave me about every two weeks. I would like it to be clean shaven more often. On 7/30/2025 at 8:27 AM during an interview and observation with Certified Nursing Assistant (CNA)#1, she confirmed that Resident #36 had facial hair on her chin and upper lip. The CNA stated that residents were typically shaved as needed on their shower days. On 7/30/2025 at 8:30 AM, during an interview with the Director of Nursing (DON) and the Administrator, it was confirmed that personal hygiene, including shaving, should have been included in the care plans for this resident. The Administrator emphasized that care plans serve as a guide for staff to follow while providing care and absolutely should have been developed. Record review of the “admission Record” revealed Resident #36 was admitted to the facility on [DATE] with medical diagnoses that included Nontraumatic Intracerebral Hemorrhage, Unspecified and Cerebral Infarction, Unspecified. Record review of the quarterly MDS with an Assessment Reference Date (ARD) of 4/18/25 revealed, under Section C revealed, a BIMS score of 13, which indicated the resident was cognitively intact.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to provide Activities of Daily Living (ADL) care to maintain personal hygiene for one (1) of four (4) residents reviewed for ADL's. (Resident #36). Findings include: Review of facility policy titled, Activities of Daily Living (ADL), Supporting revised March 2018, revealed, Policy Statement .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene . During an observation and interview on 7/29/2025 at 11:34 AM with Resident #36, it was noted that the resident had dark facial hair, approximately one-fourth of an inch long on her upper lip, along with sparce hair on her chin. The resident expressed a desire for more frequent shaving, stating, They usually shave me about every two weeks. I would like it to be clean shaven more often. During an interview and observation on 7/30/2025 at 8:27 AM with Certified Nursing Assistant (CNA) #1, she confirmed that Resident #36 had facial hair on her chin and upper lip. The CNA indicated that residents were typically shaved as needed on their shower days. During an interview on 7/30/2025 at 8:30 AM with the Director of Nursing (DON) and Administrator, it was confirmed that Residents should be shaved as needed. The Administrator stated, It's an issue, especially for women, to have unwanted facial hair. Record review of the “admission Record” revealed Resident #36 was admitted to the facility on [DATE] with medical diagnoses that included Nontraumatic Intracerebral Hemorrhage, Unspecified and Cerebral Infarction, Unspecified. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/18/25 revealed, under Section C revealed, a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, facility policy review, and record review, the facility failed to ensure medications were securely stored in the medication room for one (1) of four (4) medication storage areas observed in the facility. Findings include: Review of the facility policy titled “Storage of Medications,” last reviewed [DATE], revealed: “Policy Statement: The facility stores all drugs and biologicals in a safe, secure, and orderly manner . During the initial entrance tour of the facility on [DATE] at 6:10 PM, the medication room door on the A-hallway was observed to be open, with multiple medication cards sitting on a counter visible from the hallway. Also observed was a cup with what appeared to be medication sitting on a small cabinet, also visible from the hallway. During an observation and interview with Registered Nurse (RN) #1 on [DATE] at 6:13 PM, she confirmed the medication room door was open and stated it should never be left open. She stated the medications on the cards on the counter were from two residents who had expired over the weekend. She stated the medication in the cup was for a resident she had recently prepared, and she had set it down to go answer the front door. She confirmed she failed to shut and secure the medication room. She further revealed that the door had been open since she arrived at 5:00 PM. She stated that with the medication room door being open and medications visible, a resident or staff member could have entered and taken the medications, resulting in adverse consequences such as over-sedation or gastric issues. A continued observation of the medication in the cup on the file cabinet identified it as Seroquel 50 milligrams (mg), an antipsychotic medication. An interview with the Director of Nursing (DON) on [DATE] at 6:15 PM revealed she had not seen the medication room door open but confirmed that it should never be left open. She stated a confused resident could access the medications and ingest them, resulting in adverse complications. She confirmed the medications on the counter were from two residents who had recently expired. A continued observation of the medication cards on the counter in the A-hall medication room with the DON on [DATE] at 6:17 PM revealed the following discontinued medications and their respective classes: · Hydrochlorothiazide 12.5 mg (milligrams) (diuretic) – 10 tablets · Fluoxetine 40 mg (selective serotonin reuptake inhibitor – antidepressant) – nine (9) capsules · Wellbutrin 75 mg (norepinephrine-dopamine reuptake inhibitor – antidepressant) – 10 tablets · Remeron 7.5 mg (tetracyclic antidepressant) – 13 tablets · Procardia 30 mg (calcium channel blocker – antihypertensive) – 12 capsules (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	· Nuedexta 20 mg/10 mg (dextromethorphan/quinidine – central nervous system-active agent for pseudobulbar affect) – 12 capsules

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, staff interviews, record review, and facility policy review, the facility failed to ensure adaptive equipment was provided to a resident during dining for one (1) of seven (7) residents reviewed for dining. Resident #3 Review of the facility policy titled “Assistance with Meals” reviewed 6/18/25, revealed, “Residents Who May Benefit from Assistive Devices: 1. Adaptive devices (special eating equipment and utensils) will be provided for residents who need or request them .” An observation on 7/28/25 at 6:24 PM of Resident #3 revealed she was lying in bed. She was holding a regular spoon and dipping it into a divided plate that contained remnants of the pureed dinner meal. Record review of the 7/28/25 dinner meal ticket revealed Resident #3 was listed to have a weighted spoon and fork. Record review of Resident #3's Diet Requisition Form dated 2/5/25 revealed under, Request for services: Divided plate and weighted utensils. An observation and interview with Registered Nurse (RN) #1 on 7/28/25 at 6:31 PM confirmed Resident #3 did not have weighted utensils. She stated the resident needs them to grasp better and increase her ability to feed herself. An interview with the Dietary Manager (DM) on 7/30/25 at 8:56 AM revealed it was the kitchen staff's responsibility to ensure the adaptive equipment was sent out with the meal tray. She stated the resident was supposed to have them to assist her with eating independently. Record review of the “admission Record” revealed the facility admitted Resident #3 on 2/26/24 with a medical diagnosis of Unspecified Dementia with other Behavior Disturbance. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/26/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 3, which indicated Resident #3 was severely cognitively impaired. Bottom of Form Top of Form Top of Form Top of Form Bottom of Form Bottom of Form Bottom of Form