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 09/13/2023

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 Agency (SA) conducted a complaint investigation (CI MS# 22725) at the facility from 9/12/23 through 9/13/23. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services. The SA identified non-compliance and cited F580 for failure to notify the Resident Representative of a medication change, F584 for cleanliness of the facility, and F759 for medication error for CI MS# 22725. The census at the time of the survey was 67 with a bed capacity of 76 beds.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 580		10/13/23

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

Electronically Signed | 10/05/2023

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.

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 09/13/2023

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 580	Continued From page 1 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility document reveiew the facility failed to notify the Resident Representative (RR) of a change in a medication dosage for one (1) of four (4) residents reviewed for notification. Resident # 1 Findings include: Record review of a typed document, undated,	F 580	Preparation and submission of this plan 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.	

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 09/13/2023

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 580	Continued From page 2 and signed by the Administrator revealed "(Proper name of facility) does not have a policy related to notification of the responsible party of changes in Physician orders or treatments." Record review of the Complaint Intake information provided to the State Agency from the Resident Representative (RR) in reference to Resident #1 revealed she was not notified of the increase in the administration of a Fentanyl patch from 25 micrograms per hour (mcg/hr) to Fentanyl 50 mcg/hr. A phone interview prior to survey entrance on 9/8/23 at 2:00 PM, with Resident #1's RR, revealed all of the information regarding the complaints regarding her father-in-law was in the intake information provided to the agency. Record review of Resident # 1's "Order Summary Report" dated 9/12/23 revealed an order dated 6/30/23 "Fentanyl Transdermal Patch 72 Hour 50 mcg/hr (microgram per hour) Apply 1 (one) patch transdermally every 72 hours related to Pain, Unspecified. Remove per schedule. Record review of Resident # 1's Progress Notes *NEW* dated 6/30/23 at 13:03 (1:03 PM) revealed "Note Text: Received new order for increase Fentanyl patch to 50 mcg Q (every) 72 hours ...Orders confirmed ..." There was no documentation that the RR was notified of the increase in dosage. Record review of the Admission Record revealed Resident #1 was admitted to the facility on 9/15/22 with diagnoses that included Malignant neoplasm of upper lobe, left bronchus or lung and pain, unspecified.	F 580	1) On 9/15/23 Registered Nurse (RN) #1 was educated to document notifying the Responsible Party with any medication changes. 2) All residents that receive new or modified orders have the potential to be affected. 3) An audit of new and/or changed orders was conducted on 9/18/23 by the Medical Records Clerk for the last 30 days to ensure RP was notified; negative findings were addressed. In-services with 12 of 12 nurses was conducted on 9-14-23 by the Staff Development Coordinator on notification and documentation of RP with any new or changes in residents plan of care. 4) Beginning the week of 9/18/2023, the Medical Records Clerk and/or MDS Nurse will conduct three (3) audits weekly to ensure RPs have been notified on changes in plan of care for four (4) weeks and four (4) audits monthly for two (2) months and three (3) audits 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. On 10/12/23 Quality Assurance Performance Improvement Committee will review audits and give further recommendations if needed. The Administrator is responsible for ongoing monitoring and overall	

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 09/13/2023

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 580	Continued From page 3 During an interview on 9/12/23 at 2:00 PM, with Registered Nurse (RN) #1 verified that there was no documentation that the RR was notified of the new order to increase Resident #1's Fentanyl patch to 50 mcg/hr. She stated she did not recall notifying the RR. During an interview with the Director of Nursing and Administrator on 9/12/23 at 2:05 PM, both verified that the RR was not notified of the new order to increase the dosage of Resident #1's Fentanyl patch and the RR should have been notified. The Administrator confirmed the facility did not have a policy related to notification of RR's of new orders.	F 580	compliance.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		10/13/23

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 09/13/2023

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 584	Continued From page 4 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review the facility failed to provide a clean environment, as evidenced by staff failure to remove soiled items from the shower room for one (1) of two (2) shower rooms observed for cleanliness. Findings include: Record review of a typed document, undated, and signed by the Administrator revealed "(Proper name of facility) does not have a policy related to the cleaning of shower rooms." An observation of the A wing shower room on 9/12/23 at 8:20 AM, revealed four (4) adult briefs saturated with a yellow liquid on the floor of the	F 584	1)On 9/12/23 Certified Nursing Assistant (CNA) #1 removed four (4) soiled briefs, trash bag and wash cloth with brown substance on it from the shower room. Housekeeping Supervisor immediately cleaned shower room. 2) All residents that use the shower room have the potential to be affected. 3) The CNAs were educated on not leaving dirty linen/briefs and garbage on the floor and to clean shower room after each use on 9/14/23 by Staff Development Coordinator. The Housekeeping Supervisor was educated on ensuring cleanliness of shower rooms	

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 09/13/2023

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 584	Continued From page 5 shower room. Two (2) of the briefs were on an open trash bag and 2 briefs were directly on the floor. A wash cloth with a dry light brown substance on it was draped over the safety bar in the middle shower stall. An observation and interview with Certified Nursing Assistant (CNA) #1 on 9/12/23 at 8:21 AM, revealed housekeeping was responsible for mopping the floors, but the CNA giving showers is responsible for picking up linen and throwing away briefs. She verified that there were 4 soiled adult briefs in the A wing shower room on the floor and a wash cloth with a dry light brown substance on it draped over the safety bar in the middle shower stall. She stated the briefs and wash cloth should not be left in the shower room. During an interview with the Housekeeping Supervisor, on 9/12/23 at 8:25 AM, revealed that the housekeepers usually mopped the shower room floor during the day after the day shift staff gave showers. During an observation and interview with the Administrator, on 9/12/23 at 8:30 AM, she verified that that there were 4 soiled adult briefs on the A wing shower room floor and a wash cloth with a dry light brown substance on it was draped over the safety bar in the middle shower stall. She stated that CNAs give showers on all 3 shifts and it is likely that the night shift left the items in the shower room. She stated that the CNAs should have thrown the briefs away and removed the wash cloth. During an interview with the Administrator on 9/13/23 at 3:00 PM, she confirmed the facility did not have a policy that addressed cleaning the	F 584	on 9/15/23 by the Administrator. The Housekeeping Supervisor educated six (6) of six (6) housekeepers on cleaning shower rooms at the beginning and end of their shift. 4) Beginning the week of 9/18/23, the Housekeeping Supervisor and/or Administration Staff will conduct three (3) audits weekly to ensure cleanliness of the shower rooms for four (4) weeks and four (4) audits monthly for two (2) months and three (3) audits quarterly thereafter. The Director of Nursing and/or Charge Nurse will conduct three (3) audits weekly to ensure CNAs are cleaning shower room after each use for four (4) weeks and monthly for two (2) months and quarterly thereafter. A report will be submitted to the Quality Assurance Performance Committee for three (3) months by the Housekeeping Supervisor for review and further recommendations. On 10/12/23 Quality Assurance Performance Improvement Committee will review audits and give further recommendations if needed. The Administrator is responsible for ongoing monitoring and overall compliance.	

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 09/13/2023

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 584	Continued From page 6 shower room.	F 584		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review the facility failed to ensure staff administered and removed transdermal Fentanyl patches as ordered for one (1) of four (4) residents reviewed for the use of Fentanyl patches. Resident # 1. Findings include: Record review of the facility policy, titled "Administering Medications" with a revision date of April 2019, revealed "Policy Heading: Medications are administered in a safe and timely manner, and as prescribed...4. Medications are administered in accordance with prescriber orders, including any required time frame ...10. The individual administering the medication checks the label THREE (3) times to verify ...right dosage ..." Record review of the facility's investigation dated 7/9/23 at 15:56 (3:56 PM), revealed "Incident Description: Certified Nursing Assistant (CNA) from previous hospice company notified resident's family whom notified staff that resident had four Fentanyl patches present while she was giving resident a bath. Two (2) of the patches	F 658	1)Licensed Practical Nurse #3 removed four (4) Fentanyl Transdermal Patches on 7/9/23, destroyed patches and documented destruction. On 7/9/23 Nurse Practitioner assessed Resident #1 with no negative findings noted. 2) All residents that receive Fentanyl Transdermal Patches have the potential to be affected. 3) Twelve (12) of twelve (12) Licensed Nurses were educated on 9/15/23 by the Staff Development Coordinator on checking upper body for old patches, timely removal and proper destruction of patches. The Director of Nursing conducted an audit on 9/14/23 to ensure Fentanyl Transdermal Patches were destroyed timely and properly documented on residents; no negative issues identified. 4) Beginning the week of 9/18/23, the DON and/or RN Supervisor will conduct three (3) audits weekly to ensure Fentanyl Transdermal Patches are destroyed timely	10/13/23

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 09/13/2023

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 658	Continued From page 7 were placed by the A wing nurse. The other two patches did not have initials of date. Immediate Action Taken: TX (treatment) nurse and FNP (Family Nurse Practitioner removed patches. FNP present and assessed resident ... Mental Status Oriented to person, Oriented to situation ..." Record review of Resident # 1's "Order Summary Report" dated 9/12/23 revealed an order dated 6/30/23 "Fentanyl Transdermal Patch 72 Hour 50 mcg/hr (microgram per hour) Apply 1 (one) patch transdermally every 72 hours related to Pain, Unspecified. Remove per schedule. A record review of a General Nurse Notes-narrative for Resident #1, dated 7/9/23 12:12 PM, revealed that during medication pass Licensed Practical Nurse (LPN) #1 noticed that he had four Fentanyl 25 mcg/hr patches in place on the resident. Two patches were located on the right chest and one patch was located on the right and left arm. All four patches were removed. The Director of Nursing (DON) was notified and verbal order was obtained to hold Fentanyl until further notice. A record review of Resident #1's June 2023 Medication Administration Record (MAR) revealed that on 6/30/23 a Fentanyl 25 mcg/hr patch was documented as removed at 7:59 AM and a Fentanyl 25 mcg/hr patch was documented as applied at 8:00 AM by LPN #2. The MAR also revealed that a Fentanyl 50 mcg/hr patch was documented as applied on 6/30/23 at 1523 (3:23 PM) by LPN #2. A record review of Resident #1's "One Point Patient Care Receipt" revealed Fentanyl 25 mcg/hour patch was signed out on 6/30/23 at	F 658	through record review and proper placement of Fentanyl Transdermal Patches with body audits for four (4) weeks. Four (4) monthly audits will be performed for two (2) months and three (3) audits performed quarterly thereafter. A report will be submitted to the Quality Assurance Performance Committee for three (3) months by the Director of Nursing (DON) for review and further recommendations. On 10/12/23 Quality Assurance Performance Improvement Committee will review audits with and make further recommendations if needed. The Director of Nursing is responsible for ongoing monitoring and overall compliance.	

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 09/13/2023

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 658	Continued From page 8	F 658		

8:00 AM and 3:11 PM by LPN #2. The record revealed that the resident had no 50 mcg/hr patches.

A record review of Resident #1's July 2023 MAR revealed on 7/3/23 a Fentanyl 50 mcg/hr patch was documented as removed at 12:59 PM and a Fentanyl 50 mcg/hr patch was documented as applied at 1300 (1:00 PM) by LPN #2. On 7/6/23 a Fentanyl 50 mcg/hr patch was documented as removed at 1357 (1:57 PM) and a Fentanyl 50 mcg/hr patch was documented as applied at 1357 (1:57 PM) by LPN #3.

A record review of the "One Point Patient Care Receipt" for Resident #1's Fentanyl 25 mcg/hour patch revealed that two Fentanyl 25 mcg/hr patches were signed out on 7/3/23 at 1300 (1:00 PM) by LPN #2. There were two Fentanyl 25 mcg/hr patches signed out on 7/6/23 at 6:00 PM by LPN #3.

A record review of the "Fentanyl Patch Destruction Log" for Resident #1 revealed that there was no documentation that Fentanyl patches were destroyed on 6/30/23 or 7/3/23. There were two Fentanyl 25 mcg/hr patches documented as destroyed on 7/6/23 by LPN #3. Documentation on the log for 7/9/23 revealed that four patches were destroyed at 12:45 PM by LPN #1.

During an interview with the Director of Nurses (DON) and Administrator on 9/12/23 at 11:00 AM, both confirmed they were notified by LPN #1 on 7/9/23 that Resident #1 had four Fentanyl patches on.

During an interview with LPN #3 on 9/12/23 at

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 09/13/2023

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 658	Continued From page 9	F 658		

11:15 AM, she verified that she removed two Fentanyl 25 mcg/hr patches from Resident #1's left chest on 7/6/23 and applied two new Fentanyl 25 mcg/hr patches to the right chest. She stated she did not see any patches on resident's left or right upper arm at that time.

During a telephone interview with LPN #1 on 9/12/23 at 11:35 AM, she stated that she entered the resident's room on 7/9/23 around noon and noted two 25 mcg/hr Fentanyl patches on the resident's right chest, one 25 mcg/hr Fentanyl patch on the resident's right arm and one 25 mcg/hr Fentanyl patch on the residents left arm. She stated that she could not make out dates or initials on the patches to the right and left arms. She states she notified the supervisor and Administrator and removed and destroyed the patches.

An observation and interview with the DON and Administrator on 9/12/23 at 2:30 PM, of the "Fentanyl Patch Destruction Log" for Resident #1's Fentanyl 25 mcg, they verified that there was no documentation showing that the Fentanyl patch was destroyed on 6/30/23 or 7/3/23. They stated that they believe that two of the four 25 mcg/hr patches removed and destroyed on 7/9/23 were from 6/30/23 and 7/3/23.

During a telephone interview with LPN #2 on 9/13/23 at 9:57 AM, she stated that on 6/30/23 she removed the resident's old Fentanyl patch and then placed a Fentanyl 25 mcg patch on Resident #1. She stated she could not remember what area she removed the old patch from or where she placed the new patch. She verified that the Physician did increase the resident's dose of Fentanyl from 25 mcg/hr to Fentanyl 50 mcg/hr

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 09/13/2023

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 658	Continued From page 10	F 658		

on 6/30/23. LPN #2 verified that she did sign out an additional 25 mcg/hr patch on 6/30/23 to be applied on the resident when the dose was increased to 50 mcg/hr. She stated she does not remember where the second patch was placed on the resident. LPN #2 verified that on 7/3/23 she signed out two Fentanyl 25mcg/hr patches and placed them both on the resident after she removed the two old patches. She denied applying any Fentanyl 50 mcg/hr patches, as Resident # 1 had no 50 mcg/hr Fentanyl patches. She stated she did not recall where she removed the old patches from or where she placed the new patches. She denied seeing any additional Fentanyl patches on the resident.

During an interview with the Doctor of Pharmacy (DOP) on 9/13/23 at 10:05 AM, he stated that Fentanyl patches are manufactured so that the medication is dispersed across the entire patch for better absorption. He stated that after three days there would only be a trace amount of medication in the patch and after six days there would be no medication in the patch. The DOP stated that is is not likely that a Fentanyl patch left on a patient after three and six days would cause an alteration in mental status. He stated that depending on a patient's diagnosis, comorbidities, and current medications an increase in dosage of Fentanyl from 25 mcg/hr to 50 mcg/hr may cause an alteration in mental status.

During an interview with the Administrator on 9/13/23 at 11:00 AM, she verified that the facility failed to administer the Fentanyl patches as ordered by applying two Fentanyl 25 mcg/hr patches instead of the one Fentanyl 50 mcg/hr patches as ordered. She stated that a clarification order should have been obtained to apply two

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 09/13/2023

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 658	Continued From page 11 Fentanyl 25 mcg/hr patches. She also verified that the facility failed to remove the Fentanyl patches as ordered. Record review of the facility Admission Record for Resident #1 revealed he was admitted to the facility on 9/15/2022 with diagnoses that included Malignant Neoplasm of Upper Lobe, Left Bronchus or Lung, Chronic Pulmonary Edema, End Stage Renal Disease, and Dependence on Renal Dialysis.	F 658		