STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255228	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 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, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey with one (1) complaint investigation (CI), a facility reported incident, CI MS #478394 at the facility from 7/28/25 through 7/31/25. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation and cited, F640, F641, F656, F677, F761, F810, and F851. The SA investigated CI MS #478394 related to accident hazards and resident abuse and no deficiencies were cited related to the CI. The census at the time of the survey was 71 and the facility is licensed for 75 beds.	F0000		
F0640 SS = D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a	F0640		

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255228	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 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, Mississippi, 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
F0640 SS = D	Continued from page 1 format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: 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.	F0640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255228	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 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, Mississippi, 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
F0640 SS = D	Continued from page 2 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 2/1/25 with diagnoses including Type 2 Diabetes with Hyperglycemia.	F0640		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255228	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 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, Mississippi, 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
F0641 SS = D	Continued from page 3 §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: 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	F0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255228	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 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, Mississippi, 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
F0641 SS = D	Continued from page 4 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.	F0641		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255228	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 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, Mississippi, 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
F0656 SS = D	Continued from page 5 outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: 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,	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255228	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 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, Mississippi, 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
F0656 SS = D	Continued from page 6 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 1/9/25 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.	F0656		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: 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	F0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255228	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 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, Mississippi, 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
F0677 SS = D	Continued from page 7 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 1/9/25 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.	F0677		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by:	F0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255228	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 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, Mississippi, 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
F0761 SS = D	Continued from page 8 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 6/24/25, 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 7/28/25 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 7/28/25 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 7/28/25 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 6/28/25 at 6:17 PM revealed the following discontinued medications and their respective classes:	F0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255228	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 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, Mississippi, 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
F0761 SS = D	Continued from page 9 · 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 · Nuedexta 20 mg/10 mg (dextromethorphan/quinidine – central nervous system-active agent for pseudobulbar affect) – 12 capsules	F0761		
F0810 SS = D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is NOT MET as evidenced by: 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.	F0810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255228	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 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, Mississippi, 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
F0810 SS = D	Continued from page 10 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	F0810		
F0851 SS = F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing	F0851		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255228	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 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, Mississippi, 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
F0851 SS = F	Continued from page 11 information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS.	F0851		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255228	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 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, Mississippi, 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
F0851 SS = F	Continued from page 12 §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: 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.	F0851		