Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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**

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M0000	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 the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited, M225, M475, M610, and M705. The SA investigated CI MS #478394 related to accident hazards and abuse with no deficiencies cited. The census at the time of the survey was 71 and the facility is licensed for 75 beds.	M0000		
M0225	45.4.1 Nursing Facility Nursing Facility. To be classified as a facility, the institution shall comply with the following staffing requirements: 1. Minimum requirements for nursing staff shall be based on the ratio of two and eight-tenths (2.80) hours of direct nursing care per resident per twenty-four (24) hours. Staffing requirements are based upon resident census. Based upon the physical layout of the nursing facility, the licensing agency may increase the nursing care per resident ratio. 2. Each facility shall have the following licensed personnel as a minimum: a. Seven (7) day coverage on the day shift by a registered nurse. b. A registered nurse designated as the Director of Nursing Services, who shall be employed on a full time (five [5] days per week) basis on the day shift and be responsible for all nursing services in the facility.	M0225		

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

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M0225	Continued from page 1 c. Facilities of one-hundred eighty (180) beds or more shall have an assistant director of nursing services, who shall be a registered nurse. d. A registered nurse or licensed practical nurse shall serve as a charge nurse and be responsible for supervision of the total nursing activities in the facility during the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shift. The nurse assigned to the unit for the 11:00 p.m. to 7:00 a.m. shift may serve as both the charge nurse and medication/treatment nurse. A medication/treatment nurse for each nurses' station shall be required on all shifts. This shall be a registered nurse or licensed practical nurse. e. In facilities with sixty (60) beds or less, the director of nursing services may serve as charge nurse. f. In facilities with more than sixty (60) beds, the charge nurse may not be the director of nursing services or the medication/treatment nurse. 3. Non-Licensed Staff. The non-licensed staff shall be added to the total licensed staff, to complete the required staffing requirements. 4. There shall be at least two (2) employees in the facility at all times in the event of an emergency. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on staff interviews, record review, and facility policy review, the facility failed to maintain the required minimum staffing of 2.80 hours per resident day (HPRD) on six (6) weekend days during the second quarter of Fiscal Year 2025 (January 1, 2025 – March 31, 2025) and on one (1) out of 15 days reviewed between 7/14/25-7/28/25. Findings include: During an interview on 7/31/2025, at 9:00 AM, the Administrator revealed that the facility did not have a formal policy in place regarding staffing. The Administrator provided a statement on facility	M0225		

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M0225	Continued from page 2 letterhead dated 7/31/25 that revealed, “(Formal Name of facility) does not have a policy on staffing. (Formal Name) follows the state regulations.” Review of the Payroll-Based Journal (PBJ) Staffing Data Report for the second quarter of 2025 (January 1, 2025 – March 31, 2025) indicated that the facility triggered for low weekend staffing. Further review of the facility’s daily staffing grid revealed the HPRD fell below the required minimum 2.80 on the following six (6) dates during the second quarter of 2025: 2/22/25, with a Census of 67 and an HPRD of 2.76; 3/9/25, with a Census of 70 and an HPRD of 2.75; 3/16/25, with a Census of 65 and an HPRD of 2.75; 3/22/25, with a Census of 69 and an HPRD of 2.65; 3/23/25, with a Census of 68 and an HPRD of 2.48; and on 3/30/25, with a Census of 68 and an HPRD of 2.72. Additionally, the facility fell below the required HPRD on 7/20/25, with a Census of 70 and an HPRD of 2.57. During an interview on 7/31/25, at 9:00 AM, the Administrator confirmed that the direct care hours submitted fell below the required minimum of 2.80 hours per resident day (HPRD) on several specific dates. These dates included 2/22/25, 3/9/25, 3/16/25, 3/22/25, 3/23/25, 3/30/25, and 7/20/25.	M0225		
M0475	45.16.6 Employee Testing for Tuberculosis Employee Testing for Tuberculosis 1. Each employee, upon employment of a licensed entity and prior to contact with any patient/resident, shall be evaluated for tuberculosis by one of the following methods: a. IGRA (blood test) and an evaluation of the individual for signs and symptoms of tuberculosis by medical personnel; or b. A two-step Mantoux tuberculin skin test administered and read by a licensed medical/nursing person certified in the techniques of tuberculin testing and an evaluation of the individual for signs and symptoms of tuberculosis by a licensed Physician, Physician ' s Assistant, Nurse Practitioner or a Registered Nurse. 2. The IGRA/Mantoux testing and the evaluation of signs/symptoms may be administered/conducted on the	M0475		

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M0475	Continued from page 3 date of hire or administered/read no more than 30 days prior to the individual ' s date of hire; however, the individual must not be allowed contact with a patient or work in areas of the facility where patients have access until receipt of the results of the IGRA/assessment or at least the first of the two-step Mantoux test has been administered,/read and assessment for signs and symptoms completed. 3. If the Mantoux test is administered, results must be documented in millimeters. Documentation of the IGRA/TB skin test results and assessment must be documented in accordance with accepted standards of medical/nursing practice and must be placed in the individual ' s personnel file no later than 7 days of the individual ' s date of employment. If an IGRA is performed, results and quanitive values must be documented. 4. Any employee noted to have a newly positive IGRA, a newly positive Mantoux skin test or signs/symptoms indicative of tuberculin disease (TB) that last longer than three weeks (regardless of the size of the skin test or results of the IGRA), shall have a chest x-ray interpreted by a board certified Radiologist and be evaluated for active tuberculosis by a licensed physician within 72 hours. The employee shall not be allowed to work in any area where residents have routine access until evaluated by a physician/nurse practitioner/physician assistant and approved to return. Exceptions to this requirement may be made if the employee is asymptomatic and; a. The individual is currently receiving or can provide documentation of having received a course of tuberculosis prophylactic therapy approved by the Mississippi State Department of Health (MSDH) Tuberculosis Program for tuberculosis infection, or b. The individual is currently receiving or can provide documentation of having received a course of multi-drug chemotherapy approved by the MSDH Tuberculosis Program; or c. The individual has a documented previous significant tuberculin skin reaction or IGRA reaction. 4. For individuals noted to have a previous positive to either Mantoux testing or the IGRA, annual	M0475		

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M0475	Continued from page 4 re-evaluation for the signs and symptoms must be conducted and must be maintained as part of the employee ' s annual health screening. A follow-up annual chest x-ray is NOT required unless symptoms of active tuberculosis develop. 5. If using the Mantoux method, employees with a negative tuberculin skin test and a negative symptom assessment shall have the second step of the two-step Mantoux tuberculin skin test performed and documented in the employees ' personal record within fourteen (14) days of employment. 6. The IGRA or the two-step protocol is to be used for each employee who has not been previously skin tested and/or for whom a negative test cannot be documented within the past 12 months. If the employer has documentation that the employee has had a negative TB skin test within the past 12 months, a single test performed thirty (30) days prior to employment or immediately upon hire will fulfill the two-step requirements. As above, the employee shall not have contact with residents or be allowed to work in areas of the facility to which residents have routine access prior to reading the skin test, completing a signs and symptoms assessment and documenting the results and findings. 7. All staff noted as negative per the IGRA blood test or who do not have a significant Mantoux tuberculin skin test reaction (reaction of less than 5 millimeters in size) shall be retested annually within thirty (30) days of the anniversary of their last IGRA or Mantoux tuberculin skin test. Staff exposed to an active infectious case of tuberculosis between annual tuberculin skin tests shall be treated as contacts and be managed appropriately. Individuals found to have a significant Mantoux tuberculin skin test reaction and a chest x-ray not suggestive of active tuberculosis, shall be evaluated by a physician or nurse practitioner/physician assistant for treatment of latent tuberculin infection. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on staff interview and record review, the facility failed to ensure completion of a baseline Tuberculosis (TB) testing requirement for one (1) of five (5) newly hired employees. Employee #1	M0475		

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M0475	Continued from page 5 Review of the typed statement on facility letterhead dated 7/31/25 and signed by the Administrator revealed the facility does not have a policy on TB and the facility follows the state regulations." Record review revealed Employee #1 was a new hire and began working on 7/14/25. The employee brought results of a previous tuberculin skin test that was administered on 5/7/25 and had results of zero (0) induration on 5/9/25. There was no documentation that the facility did a TB skin test on hire. Record review of Employee #1's timecard revealed she worked 7/14/25, 7/15/25, 7/16/25, 7/18/25, 7/28/25, 7/29/25, 7/30/25, and 7/31/25. An interview with the Infection Preventionist (IP) on 7/31/25 at 8:30 AM confirmed that Employee #1 did not receive a tuberculosis (TB) test upon hire. The IP stated the employee brought in TB test results from May, which she believed were acceptable. However, she acknowledged that the test was completed more than 30 days prior to the hire date (7/14/25) and that there was no documentation of a prior negative TB test within the past year. She agreed the two-step TB testing process for Employee #1 should be restarted. She also acknowledged that failure to follow proper testing procedures could result in the spread of tuberculosis to staff and residents.	M0475		
M0610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II	M0610		

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M0610	Continued from page 6 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 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.	M0610		
M0705	45.24.2 Policies and procedures Policies and procedures. Each facility shall have policies and procedures to assure the following:	M0705		

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M0705	Continued from page 7 1. Accurate acquiring; 2. Receiving; 3. Dispensing; 4. Storage; and 5. Administration of all drugs and biologicals. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II 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	M0705		

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M0705	Continued from page 8 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: · 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	M0705		