MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06CI	A. BUILDING: _____ B. WING _____	C 03/23/2021

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) COMPLETE DATE
M 000	Initial Comments CI MS #16523, CI MS #16842, CI MS #17205, CI MS #17642 & CI MS #17652 The State Agency (SA) conducted a complaint survey, CI MS #16842, CI MS #17205, CI MS #17642, and CI MS #17652 from 03/19/2021 through 03/23/2021. The SA determined that the facility was in compliance with the Minimum Standards for the Aged or Infirm requirements for participation. During the survey, the SA did not substantiate complaint CI MS #16842 for physical abuse of an aide to a resident, CI MS #17205 for verbal abuse of an aide to a resident, MS #17642 for quality of care and treatment related to incontinence care not provided timely and CI MS #17652 for resident neglect regarding pressure ulcer care, not being turned and repositioned timely and incontinence care not provided, with no deficiencies cited. The census at the time of the survey was 60 with a bed capacity of 75.	M 000		

Mississippi State Department of Health

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