

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255228	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/23/2021
NAME OF PROVIDER OR SUPPLIER DELTA REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 Medicare and Medicaid Services 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.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.