STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255310	A. BUILDING _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS HEALTH & REHAB	503 SILVER CROSS DRIVE BROOKHAVEN, MS 39601

(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 an annual recertification survey at the facility from 05/13/2024 through 05/16/2024. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F656, F657, F677 and F686. The facility had a census of 50 and was licensed for 60 beds.	F 000		
F 656 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	F 656		6/29/24

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

Electronically Signed | 06/05/2024

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.

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F 656	Continued From page 1 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 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 interviews, record reviews, and facility policy review the facility failed to ensure the comprehensive care plan interventions was implemented for a resident who was dependent for Activities of Daily Living (ADL) care for one (1) of 15 sampled residents. Resident #44. Findings include: Review of the facility's policy titled, "Comprehensive Plan of Care," revised 10/10/22 revealed, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656	" Certified Nursing Assistant (CNA) #3 was in serviced by the Director of Nursing (DON) on the importance of Activities of Daily Living (ADL) Care with the emphasis of Oral care on 6/3/2024. " The facility has determined that all residents have the potential to be affected. " All CNA□s will be in serviced by the Staff Educator on ADL care with the emphasis on oral care by 6/21/24. " The DON and Quality Assurance (QA) nurse will observe oral care on 4 residents weekly for 8 consecutive weeks then on 2 residents weekly for 4 consecutive weeks starting 6/3/24. " Audits will be reviewed by the Quality	

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F 656	Continued From page 2 needs that are identified in the resident's comprehensive assessment ... Policy Explanation and Compliance Guidelines: ... 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being ... f. Resident specific interventions that reflect the resident's needs and preferences ..." Record review of the Comprehensive Care Plan for Resident #44, undated, revealed, "(Proper Name of Resident #44) has an ADL self-care performance deficit ...Interventions ...Personal hygiene/oral care: The resident is totally dependent on 1-2 staff for personal hygiene and oral care. During an interview on 5/13/24 at 11:59 AM, Resident #44 revealed she wanted to brush her teeth. She revealed that in the past, she had mentioned brushing her teeth to the staff, but did not remember the last time that she had mentioned it. During an interview on 5/14/24 at 4:55 PM, Resident #44 confirmed that she had not brushed her teeth again today. During an interview on 05/15/24 at 11:14 AM, Certified Nursing Assistant (CNA) #3, confirmed that she had not assisted Resident #44 with oral care yesterday and had not yet assisted the resident with oral care today. She revealed that oral care should be done daily, before breakfast, as it helps the food to taste better. During an interview on 05/16/24 at 10:10 AM, in	F 656	Assurance (QA) committee on 6/28/24 them monthly until substantial compliance has been achieved by the committee.	

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F 656	Continued From page 3 an interview with Registered Nurse (RN) #1/Care Plan Nurse, she revealed the Comprehensive Care Plan is done to drive the care of the resident, as it lets the staff know what the resident needs, and guides personalized care. The nurse stated oral care is part of ADL care. Review of the "Admission Record," for Resident #44 revealed that the facility admitted the resident on 5/25/23. Current diagnoses included Unspecified Lack of Coordination, Muscle Weakness (Generalized), and Hemiplegia and Hemiparesis Following Cerebral Infarction affecting Left Non-Dominant Side.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657		6/29/24

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F 657	Continued From page 4 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record reviews and facility policy review, the facility failed to revise comprehensive care plan interventions for falls for one (1) of two (2) residents reviewed for accidents. (Resident #9) Findings include: A review of the facility's policy, "Comprehensive Plan of Care", revised 10/10/2022, revealed, " ...It is the policy of this facility to develop and implement a comprehensive care plan for each resident ...Policy Explanation and Compliance Guidelines ...5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS (Minimum Data Set) assessment..." A record review of the of the comprehensive care plan for Resident #9 revealed "Focus (Proper Name) is at risk for falls r/t (related to) history of frequent/recurrent/repeated falls ...Interventions 1/1/21-Colored tape to wheelchair for identification of chair ...12/1/20-Cup holder attached to 1/4 side rail while in bed ...3/23/21-Resident to have TV remote attached to bedside table ...3/25/24-Anti-rollbacks to wheelchair ...4/25/22-Reacher secured to wheelchair ...6/23/22-Mirror mounted to wall near bed ...7/10/22-Resident may have raised toilet	F 657	" On 5/31/24 the Minimum Data Set (MDS) coordinator updated the care plan for Resident # 9. " All residents with a fall care plan have the potential to be affected by this practice. " The facility□s MDS team attended an in-service presented by the Director of Nursing on the comprehensive plan of care policy on 6/3/24. 100% audit will be conducted beginning 6/3/24 on all fall care plans and Point of Care (POC) in Point Click Care (PCC) by the Interdisciplinary Team (IDT). " The Director of Nursing or Quality Assurance (QA) nurse will conduct a care plan audit on 4 residents weekly for 8 consecutive weeks then on 2 residents care-plans weekly for 4 consecutive weeks starting 6/3/24. " Audits will be reviewed by the Quality Assurance committee on 6/28/24 then monthly until substantial compliance has been achieved by the committee. .	

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F 657	Continued From page 5	F 657		

seat for use as needed ...9/25/20 Dycem (slip resistant material) on top of and underneath wheelchair cushion ..."

On 5/14/24 at 2:45 PM, in an observation, Resident #9 was not in her room. There was no cupholder observed attached to the bed rail, the TV remote was not attached to the bedside table, and there was no mirror mounted to the wall near her bed.

On 5/14/24 at 2:50 PM, in an interview and observation, Registered Nurse (RN) #1 explained she was the care plan and MDS nurse for the facility. RN #1 reported that she did not resolve care plan interventions related to falls if they were still active. She reviewed and acknowledged Resident #9 had care plan interventions for falls that were from 2020. In an observation of Resident #9's room, RN #1 confirmed there was no cup holder attached to the side rail, the TV remote was not attached to the bedside table, and there was no mirror mounted to wall near the bed. Resident #9 was not in her room at the time of the observation. RN #1 explained she did not reconcile the interventions or conduct visual inspections to ensure the interventions that are listed on the care plan are being provided to the resident.

On 5/14/24 at 3:16 PM, in an observation and interview with Certified Nurse Aide (CNA) #1, she explained that she was assigned to care for Resident #9 at times. CNA #1 used the Point of Care (POC) kiosk to review the Kardex for Resident #9 which included fall interventions. In an observation of the resident's room, CNA #1 confirmed there was no cup holder attached to the side rail and she believed the resident had not

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F 657	Continued From page 6	F 657		

had one for a long time because she assists her to bed sometimes. She also confirmed there was no mirror mounted to the wall near the bed and the TV remote was not attached to the bedside table. CNA #1 said she thought the TV remote used to have Velcro to attach it to the bedside table, but she believed Resident #9 had gotten a new table since then. Resident #9 was not in her room at the time of the observation.

On 5/14/24 at 03:40 PM, in an interview and observation with Resident #9, she was sitting in her room in her wheelchair. The wheelchair did not have an anti-rollback device attached to her chair, there was no colored tape on her wheelchair, there was no reacher secured to her wheelchair, and there was no dycem on or underneath her wheelchair cushion. Resident #9 remarked that she does not think there has ever been a mirror mounted on the wall near her bed or a cup holder on bed rail, and acknowledged there was no anti rollback device applied to her chair, no colored tape on her chair, there was no dycem material on her chair cushion, and there was no reacher mounted to the wheelchair she was sitting in. She stated she was not sure if she ever had those things on her wheelchair. Review of the resident's toilet revealed there was an over commode chair in place.

On 5/15/24 at 8:47 AM, in an interview with the Director of Nursing, she stated that previously, the staff completed random care plan audits to ensure the care plan interventions were revised to accurately reflect the current interventions the resident required. The DON stated she had been made aware there were numerous care plan interventions related to falls for Resident #9 that were old and the care plan should have been

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F 657	Continued From page 7 revised to reflect the resident's current needs. There was also an intervention for "Resident may have raised toilet seat for use as needed" that should have been revised on 12/16/23 when Resident #9 had a fall in which the intervention was for "therapy to evaluate for over commode chair and remove raised toilet seat". She stated when the care plan nurse advised her of the issue with Resident #9's fall care plan yesterday, the facility immediately reviewed and revised the interventions. The DON commented that although there were many interventions for falls that were being implemented for Resident #9, there were several interventions that should have been resolved because they were old. A record review of the "Admission Record" revealed the facility initially admitted Resident #9 on 6/26/20 and she had current diagnoses including Unspecified lack of coordination. A record review of the Quarterly MDS with an Assessment Reference Date (ARD) of 2/28/24 revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact.	F 657		
F 677 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 staff and resident interviews, record reviews, and facility policy review, the facility failed to ensure dependent residents received the	F 677	" Oral care was provided for resident(s) #44 on 5/15/24. The DON conducted a one-on one in-service with the CNA on the	6/29/24

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F 677	Continued From page 8 necessary services to maintain oral hygiene for one (1) or 15 sampled residents. Resident #44. Findings include: Review of the facility's policy, "Activities of Daily Living (ADL)," revised 9/15/22, revealed, "Based on the resident's comprehensive assessment and consistent with the resident's needs and choices, the facility will ensure a resident's abilities in ADL's do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming, and oral care; ... Policy Explanation and Compliance Guidelines: ...3.A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene ..." In an interview 05/13/24 at 11:59 AM, Resident #44 stated that she wants her teeth brushed. The resident stated that the staff give her a bed bath daily and fix her hair, but they do not help her brush her teeth. She revealed that she has mentioned to the staff that she would like to brush her teeth, but does not recall the last time she mentioned it to them. In an interview on 05/14/24 at 4:55 PM, Resident #44, she revealed that she did not get to brush her teeth again today and the staff never mentioned oral care. The resident stated that in the past, she would brush her teeth twice a day, but at this point, she would be happy if she could just brush them once a day. In an interview on 05/15/24 at 11:14 AM, in an interview with Certified Nursing Assistant (CNA)	F 677	importance of Oral Hygiene on 6/3/24. " The facility has determined that all residents have the potential to be affected. " An in-service on Oral Hygiene was conducted by the Director of Nursing and Staff Educator with all direct care staff addressing oral care beginning on 5/31/24 with all direct staff completing in-service by 6/14/24. " The QA nurse, DON, or staff educator nurse will observe oral care on 4 residents weekly for 8 consecutive weeks then on 2 residents weekly for 4 consecutive weeks starting 6/3/24. " Audits will be reviewed by the Quality Assurance committee on 6/28/24 then monthly until substantial compliance has been achieved by the committee.	

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F 677	Continued From page 9 #3, she revealed that brushing a resident's teeth is part of ADL care. The CNA confirmed she did not assist Resident #44 to brush her teeth today or yesterday, but would do so now. She confirmed oral care should be done in the AM, before breakfast, as cleaning the mouth helps to make food taste better. In an interview on 05/16/24 at 10:26 AM, the Director of Nurses (DON), revealed that oral care if part of ADL care, and she expects staff to provide oral care every shift. She stated good oral hygiene decreases the risk of a resident developing an oral infection. Record review of the "Admission Record" of Resident #44 revealed the facility admitted the resident on 5/25/23. Diagnoses included Muscle Weakness (Generalized), and Unspecified Lack of Coordination. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/14/24, revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. Section GG revealed the resident requires supervision or touching assistance with oral hygiene. Record review of the "Task List Report," for Resident #44, revealed the task of Personal Hygiene was initiated on 9/5/23. The task was to be performed by a CNA every shift and prn (as needed).	F 677		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		6/29/24

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The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism

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F 880	Continued From page 11 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure treatment of pressure ulcers was provided in a manner to prevent cross contamination and promote healing, as evidenced by failure to change gloves and perform proper hand hygiene during wound care for one (1) of two (2) residents reviewed for pressure ulcers. Resident #36 Findings include: On 5/15/24 at 11:03 AM, an observation of wound care for Resident #36 revealed Licensed Practical	F 880	" Licensed Practical Nurse (LPN) #1 was in-serviced by the Director of Nursing (DON) on the importance of removing soiled gloves, preforming hand hygiene and applying clean gloves prior to applying treatment medication on 5/16/24. LPN #1 was checked off on wound care after being in-serviced on 5/16/24 and again on 5/17/24 by the DON. " The facility has determined that all residents that have a wound have the potential to be affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255310	A. BUILDING _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS HEALTH & REHAB	503 SILVER CROSS DRIVE BROOKHAVEN, MS 39601

(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 880	Continued From page 12 Nurse (LPN) #1 did not removed her soiled gloves, perform hand hygiene, and apply clean gloves prior to applying alginate to the wound bed and covering with a border dressing. On 05/15/24 at 11:10 AM, in an interview with LPN #1, she confirmed she forgot to remove her soiled gloves after cleaning the resident's wound. She stated she should have removed her gloves, performed hand hygiene, and applied clean gloves before applying the clean dressing. LPN #1 stated her action could lead to contamination of the wound and was considered an infection control issue. On 05/16/24 at 10:32 AM, in an interview with the Director of Nurses (DON), she confirmed LPN #1 should have changed her gloves after cleaning the wound. She stated LPN #1 should have performed hand hygiene after cleaning the wound and should have donned new gloves before applying the clean dressing. She stated this was an infection control issue and could delay wound healing. Review of the "Admission Record" revealed the facility admitted the resident on 5/8/23. Diagnoses included Pressure Ulcer of Sacral Region, Stage 4 and Disorder of the Skin and Subcutaneous Tissue, Unspecified.	F 880	" LPN #1 was in-serviced on the Infection control Policy by the Infection Preventionist Nurse on 6/5/24. " The DON and Staff Educator nurse will observe wound care on 2 residents weekly for 8 consecutive weeks then on 2 residents weekly for 4 consecutive weeks starting 6/3/24. " Audits will be reviewed by the Quality Assurance committee on 6/28/24 then monthly until substantial compliance has been achieved by the committee	