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 _____	10/10/2019

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 CI MS #16286 The State Survey Agency (SA) conducted an annual recertification from 10/7/19 through 10/10/19. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited regulatory deficiencies F623, F625, F656, F690, F812, and F880. The State Agency (SA) investigated one (1) complaint (CI) MS #16286, involving allegations of resident abuse and dignity. Upon investigation, the SA could not substantiate any alleged abuse or dignity issues regarding these matters. At the time of the survey, the census was 55 and the facility held a license for 60 beds.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		11/25/19

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

Electronically Signed | 11/01/2019

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.

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 _____	10/10/2019

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 623	Continued From page 1 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;	F 623		

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 _____	10/10/2019

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 623	Continued From page 2 (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by:	F 623		

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 _____	10/10/2019

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 623	Continued From page 3 Based on staff interviews, record review, and facility policy review, the facility failed to notify the Resident Representative, in writing, of the reason for transfer to the hospital for one (1) of four (4) residents reviewed for hospitalizations, Resident #13. Findings include: Review of the facility's "Resident Transfer" policy, revised 11/28/17, revealed that residents who become critically ill shall be transferred to the proper level of care, the physician and family would be notified of the residents condition. No specifics were listed on the policy as to how to notify family at the time of transfer. Review of Resident #13's "Transfer Summary", dated 7/17/19 at 3:11 PM, revealed to send the resident to hospital for evaluation and treatment of decreased level of consciousness. There was no documented evidence of a written notification to the resident or resident representative of the reason for Resident #13's transfer. Review of Resident #13's physician orders and Nurse's Notes for Resident #13, revealed a transfer order to the local hospital on 7/17/19. An observation and interview on 10/8/19 at 10:00 AM, revealed Resident #13 revealed was disoriented to place and not able to recall a hospital stay in July 2019. Interview on 10/08/19 at 4:39 PM, with the Social Service (SS) representative revealed Resident #13 was only out to the hospital for a few days. The Social Services representative said there	F 623	*On 10/14/19, written notification was mailed to resident #13's representative by Social Services explaining transfer, reason for transfer, and location of transfer of resident #13 on 7/17/19. *All residents transferred out of facility have the potential to be affected by this deficient practice. *On 10/14/19, Social Services, Business Office Manager, Director Of Care Transition, and Quality Assurance Registered Nurse were in-serviced on written notice of transfer by Director Of Nursing. *Starting on 10/15/19, all residents transferred out of facility will be notified or resident's representative will be notified in writing of transfer, reason for transfer, and location of transfer upon transfer by Social Services. If Social Services unavailable, Business Office Manager or Director Of Care Transition will be responsible for written notification of transfer. Quality Assurance Registered Nurse will audit written notification of transfer and any supporting documentation weekly for three months and monthly thereafter. *Any discrepancies will be brought to Quality Assurance Committee monthly by Quality Assurance Registered Nurse. The Quality Assurance Committee will make recommendations and/or changes as needed to ensure compliance.	

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 _____	10/10/2019

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 623	Continued From page 4 was not a written notification sent to Resident #13's representative. The SS representative said the family would be notified verbally over the phone about the reason for transfer. Interview on 10/09/19 at 10:58 AM, with the Director of Nursing (DON), revealed the policy of the facility was to notify the family by phone of the reason of transfer at the time of the transfer. The DON confirmed there was no written notification sent to the resident or the resident representative. She said the nurses were not trained to give any notification of bedhold or written notification at time of transfer. The DON said would have to read up on the regulations and have more training with the staff.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1)	F 625		11/25/19

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 _____	10/10/2019

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 625	Continued From page 5 of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to notify the Resident Representative in writing of the facility policy for bed-hold for one (1) of four (4) residents reviewed for bed-hold, Resident #13. Findings include: Review of facility policy titled "Bed Hold Policy", undated, revealed copies of the bed hold policy were kept at the nurse's station and a copy would be given to the resident or responsible party at the time of the transfer to the hospital. Review of Resident #13's physician orders revealed a transfer order to the local hospital on 7/17/19. Review of Resident #13's Nurses Notes revealed she was transferred to a local hospital on 7/17/19. Review of Resident #13's "Transfer Summary", dated 7/17/19, revealed to send the resident to hospital for evaluation and treatment of decreased level of consciousness.	F 625	*On 10/14/19, written notification was mailed to resident #13□s representative by Social Services explaining bed hold policy for resident #13 on 7/17/19. *All residents transferred out of facility have the potential to be affected by this deficient practice. *On 10/14/19, Social Services, Business Office Manager, Director Of Care Transition, and Quality Assurance Registered Nurse were in-serviced on written notice of bed hold policy by Director Of Nursing. *Starting on 10/15/19, all residents transferred out of facility will be notified or resident's representative will be notified in writing of bed hold policy, upon transfer by Social Services. If Social Services unavailable, Business Office Manager or Director Of Care Transition will be responsible for written notification of bed hold policy. Quality Assurance Registered Nurse will audit written notification of bed hold policy and supporting documentation weekly for three months and monthly	

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 _____	10/10/2019

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 625	Continued From page 6 During an interview on 10/08/19 at 4:39 PM, the Social Service (SS) Representative said that Resident #13 was only out to the hospital for a few days and she said the policy of the facility was to send out bed hold letters after 14 days if the resident is on Medicaid. During an interview on 10/09/19 at 10:58 AM, the Director of Nursing (DON) said the policy of the facility was to notify the family by phone of the reason of transfer at the time of the transfer. The DON said it was the responsibility of the SS Representative to notify the family of bedhold after the admission process. The DON said would have to read up on the regulations and have more training with the staff.	F 625	thereafter. *Any discrepancies will be brought to Quality Assurance Committee monthly by Quality Assurance Registered Nurse. The Quality Assurance Committee will make recommendations and/or changes as needed to ensure compliance.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		11/25/19

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 _____	10/10/2019

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 656	Continued From page 7 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 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review, and facility policy review, the facility failed to follow the comprehensive care plan related to catheter care for one (1) of 19 resident care plans reviewed, Resident #28. Findings include: A review of the facility's "Comprehensive Plan of Care" policy revealed the facility staff will use the objectives to monitor resident progress. The comprehensive care plan, with an onset date of 8/27/19, included interventions for an indwelling urinary catheter, which included a securing device.	F 656	*On 10/7/19, Certified Nursing Assistant #1 and Certified Nursing Assistant #2 for 7am-3pm shift assigned to resident #28 were in-serviced on catheter care, catheter leg strap, and following plan of care by Staff Educator Registered Nurse. On10/7/19, catheter leg strap was applied to resident #28 per assigned 7am-3pm Certified Nursing Assistants. On 10/9/19, resident #28 discharged home from facility after completion of rehab services. *All residents requiring an indwelling foley catheter have the potential to be affected by this deficient practice. There are currently two residents with an indwelling	

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 _____	10/10/2019

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 656	Continued From page 8 An order, dated 9/19/19, revealed Resident #28 had orders for a 16 French (FR) 10 Cubic Centimeter (CC) bulb indwelling Foley Catheter: Ensure Fig Leaf Bag in place for privacy, and leg strap in place Q shift. On 10/07/19 at 10:59 AM, an observation revealed Resident #28 awake, alert, and sitting in his wheelchair. Resident #28 was observed to have a catheter drainage bag strapped to his right lower leg. Observation of Resident #28, during catheter care, on 10/08/19 at 2:45 PM, provided by Certified Nursing Assistant (CNA) #2 and CNA #1, revealed the resident did not have a securing device in place to either of his thighs. On 10/10/19 at 12:08 PM, an interview with Registered Nurse (RN) #5 revealed she would expect the CNAs to follow the Smart Charting care plan and the guidelines when providing catheter care.	F 656	foley catheter in the facility. *On 10/14/19-10/25/19, all Certified Nursing Assistants and all nursing staff were in-serviced by Staff Educator Registered Nurse on following plan of care. On 10/14/19-11/1/19, all Certified Nursing Assistants performed catheter care skills check offs with Staff Educator Registered Nurse. Beginning 11/1/19, Staff Educator Registered Nurse will perform skills check offs with three Certified Nursing Assistants weekly for four weeks then monthly thereafter for two months. *Any discrepancies will be brought to Quality Assurance Committee monthly by Staff Educator Registered Nurse. The Quality Assurance Committee will make recommendations and/or changes as needed to ensure compliance.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must	F 690		11/25/19

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 _____	10/10/2019

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 690	Continued From page 9 ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review, and facility policy review, the facility failed to provide catheter care in a manner to prevent possible trauma for one (1) of two (2) resident catheter care observations, Resident #28. Findings include: A review of the facility's policy titled "Catheter Care", with an effective date of 3/6/15, revealed catheter care shall follow the facility guidelines. A review of Perry and Potter Eighth Edition, page 590, revealed to avoid placing tension on the	F 690	*On 10/7/19, Certified Nursing Assistant #1 and Certified Nursing Assistant #2 for 7am-3pm shift assigned to resident #28 were in-serviced on catheter care and applying catheter leg strap by Staff Educator Registered Nurse. On 10/7/19, catheter leg strap was applied to resident #28 per assigned 7am-3pm Certified Nursing Assistants. On 10/9/19, resident #28 discharged home from facility after completion of rehab services. *All residents requiring an indwelling foley catheter 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 _____	10/10/2019

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 690	Continued From page 10 catheter. On 10/08/19 at 2:45 PM, observation revealed Certified Nursing Assistant (CNA) #2 and CNA #1 set up to perform catheter care on Resident #28. Both CNA #1 and CNA #2 washed their hands, applied clean gloves, and began care. When CNA #1 unfastened Resident #28's brief, the resident did not have a securing device in place to either of his thighs. On 10/07/19 at 10:59 AM, an observation revealed, Resident #28 awake, alert and sitting in his wheelchair. Resident #28 was observed to have a catheter drainage bag strapped to his right lower leg. A record review of the physician orders, dated 9/27/19, indicated an order for a leg bag during the day and large bag at night. An order dated 9/19/19, revealed orders for a Fig Leaf Bag in place for privacy, leg strap in place Q shift: Catheter bag should always be below the level of the bladder. On 10/09/19 at 9:05 AM, an interview with CNA #1 revealed, there was not a catheter securing device in place to the Resident 28's thigh areas. On 10/09/19 at 9:10 AM, an interview with CNA #2 revealed there was not a securing device in place to the resident's thigh areas. On 10/09/19 at 9:36 AM, an interview with the Director of Nursing (DON) revealed the resident not having a securing device could cause tension on the catheter. On 10/09/19 at 10:05 AM, an interview with RN	F 690	by this deficient practice. There are currently two residents with indwelling an foley catheter in the facility. *On 10/14/19-10/25/19, all Certified Nursing Assistants and all nursing staff were in-serviced by Staff Educator Registered Nurse on following catheter care and applying catheter leg strap. On 10/14/19-11/1/19, all Certified Nursing Assistants performed catheter care skills check offs with Staff Educator Registered Nurse. Beginning 11/1/19, Staff Educator Registered Nurse will perform skills check offs with three Certified Nursing Assistants weekly for four weeks then monthly thereafter for two months. Beginning 10/14/19, Quality Assurance Registered Nurse will audit catheter leg straps to ensure placement of catheter leg straps weekly for four weeks then monthly for two months. *Any discrepancies will be brought to Quality Assurance Committee monthly by Quality Assurance Registered Nurse. The Quality Assurance Committee will make recommendations and/or changes as needed to ensure compliance.	

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 _____	10/10/2019

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 690	Continued From page 11 #1 revealed CNA #1 and CNA #2 should have ensured a securing device on the catheter tubing, to prevent tension from being on the catheter tubing, and to prevent "tugging" on the catheter tubing.	F 690		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record review, and facility policy review, the facility failed to store foods in a manner to prevent possible contamination and failed to remove expired food and milk from the refrigerator and milk cooler. Findings Include: A review of facility policy revealed that the first	F 812	*On 10/7/19, thermometer was immediately placed in freezer by Dietary Manager. On 10/7/19, Dietary Aide #2 was in-serviced by Dietary Manager on freezer temperatures, ensuring thermometer in all freezers and refrigerators, and accurate documentation of freezer and refrigerator temps. On 10/7/19, dented cans were removed by	11/25/19

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 _____	10/10/2019

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 812	Continued From page 12 priority should be obtaining and documenting the temperatures for the freezer and refrigerator milk cooler when starting the morning shift. If temperatures are above the recommended 41 degrees Fahrenheit (F) for the refrigerator and milk cooler when starting the shift and/or above 0 degrees F for the freezer, contact maintenance immediately. All foods should be covered, labeled, and dated. Products should also be assessed to assure there is no spoilage (sour smell or taste, mold, etc.) and that expiration dates are reasonable, so that products can be used in a timely fashion. Expired milk will be separated. It will be labeled that milk is expired with signage and staff will be alerted. If a freezer does not have a thermometer, staff will immediately notify the Dietary Manager. The thermometer should be checked at least twice each day. Do not record temperatures if there is not a thermometer in the freezer. Inspect all canned foods upon on delivery. Remove any dented cans and place dented cans in the designated area labeled dented cans. On 10/07/19 at 10:10 AM, an initial tour of the kitchen revealed a freezer without a thermometer in it. It contain two (2) boxes of frozen biscuits and four (4) plastic bags of rolls. The temperature log sheet had recordings done for 10/07/2019 AM and PM. While checking canned goods, observation revealed two (2) dented cans of vegetables that had not been moved to the dented area of the kitchen. A check of the refrigerator revealed a half plastic container of strawberries with mold and the container had no date. The milk cooler contained two (2) crates of out-dated milk, 32 cartons of 2 percent (%) dated 10/4/19, and three (3) cartons 2% milk dated 10/5/2019. There were seven (7) chocolate milk	F 812	Dietary Manager. On 10/8/19, half plastic carton of molded strawberries were removed from refrigerator by Dietary Manager. *All residents have the potential to be affected by this deficient practice. *On 10/10/19, all dietary personnel were in-serviced by Dietary Manager and Regional Supervisor for contracted dining services on expired milk, thermometers in all freezers and refrigerators, accurate documentation of freezer and refrigerator temperatures, dates labeled on open food items, and dented cans. Beginning 10/14/19, Dietary Manager to audit for expired milk, thermometers in all freezers and refrigerators, accurate documentation of freezer and refrigerator temperatures, dates labeled on open food items, and dented cans daily Monday through Friday for two weeks, weekly for 4 weeks, then monthly thereafter for two months. *Any discrepancies will be brought to Quality Assurance Committee monthly by Dietary Manager. The Quality Assurance Committee will make recommendations and/or changes as needed to ensure compliance.	

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 _____	10/10/2019

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 812	Continued From page 13	F 812		

cartons dated 10/4/2019, and four (4) fat free milk dated 10/7/2019.

On 10/07/2019 at 10:55 AM, an interview with the Dietary Manager (DM) revealed she removes spoiled food from the refrigerator on Monday and Thursday before the food truck comes. The DM stated expired milk is to be left in the milk cooler, in a separate crate, until the milkman comes to pick it up.

On 10/07/2019 at 11:10 AM, an interview with Dietary Aide #2 revealed he did not see a thermometer in the biscuit freezer. He stated, "I was in a rush and I just wrote something down for the AM and PM temperature".

On 10/08/2019 at 1:08 PM, a tour of the kitchen revealed the half plastic carton of molded strawberries remained in the refrigerator, with no date.

On 10/08/2019 at 10:50 AM, an interview with the DM revealed she estimated the thermometer had been missing since last Friday (10/4/2019). She stated the staff have been trained to inform her of missing thermometers and not to document falsely on temperature logs. She stated that her dish washing staff are responsible for checking temperatures and documenting them. She confirmed she forgot to take out the molded strawberries and write a date on them when she opened them. She stated she did not see the dented cans, if she had she would have moved them to the dented can sections in the storage area. She stated she usually does an in-service monthly. She also stated expired milk can cause the residents to be served sour milk. She stated that she should have removed the expired milk

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 _____	10/10/2019

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 812	Continued From page 14 from the milk cooler. On 10/09/2019 at 11:08 AM, an interview with Dietary Aide #2 revealed he has had in-services on monitoring temperatures in the freezer and refrigerator. He also stated it was a long morning and he was in a rush to get things done. He stated that he can not recall the last time they had in-services. He confirmed that he should have contacted the Dietary Manager about the missing thermometer. On 10/10/19 at 10:53 AM, an interview with the Administrator revealed the expired milk should have been removed from the milk cooler and the dented cans should have been removed from the can storage area; that the refrigerator items should be checked and removed daily. The Administrator stated falsifying temperature logs can effect the residents well being. He stated that the food not stored properly can potentially effect the well being of the residents. He also stated oversight issues has a potential to cause harm to the residents.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control 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	F 880		11/25/19

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 _____	10/10/2019

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 15	F 880		

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 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

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 _____	10/10/2019

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 16 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, staff interviews, record reviews, and facility policy review, the facility failed to provide wound care in a manner to prevent possible infection for two (2) of three (3) resident wound care observations, Resident #37 and Resident #28. And, failed to provide catheter care in a manner to prevent the possible spread of infection for one (1) of two (2) catheter care observations, Resident #45. This affected three (3) of five (5) resident care observations. Findings include: Review of the facility's "Standard Precautions" policy, Section: Infection Prevention and Control,revealed: It is the policy of the facility to provide patient care services that reflect the "Standard Precautions" infection control practices when interacting with residents. Standard Precaution components include, but are not limited to, the following: Hand Hygiene-Personal Protective Equipment (gloves, masks, gowns, etc.)	F 880	*On 10/8/19, Certified Nursing Assistant #1 and Certified Nursing Assistant #2 were in-serviced by Staff Educator Registered Nurse on infection control during catheter care and proper handling of dirty linen and trash during resident care. On 10/7/19, Registered Nurse #3 was in-serviced on infection control during catheter care. On 10/8/19, Registered Nurse #3 was in-serviced on infection control during wound care and proper handwashing during wound care. *All residents requiring indwelling foley catheter or wound care have the potential to be affected by this deficient practice. There are currently two residents with an indwelling foley catheter in facility. There are currently no residents with pressure ulcers in the facility. *On 10/14/19-10/25/19, all Certified Nursing Assistants were in-serviced on	

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 _____	10/10/2019

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 17 Review of the Facility Policy and Procedure, "Treatment Observation Checkoff", revealed: Wash hands and put on clean gloves, loosen tape and remove the existing dressing, discard into appropriate receptacle. Wash hands and put on gloves. Cleanse wound as ordered, dress wound as ordered, discard disposables and gloves, then wash hands. Universal Precautions Observed. Review of the facility's policy "Hand Hygiene in Healthcare Settings", revealed: Protect yourself and your patients from potentially deadly germs by cleaning your hands. Be sure you clean your hands the right way at the right times. A review of the facility's policy titled "Infection Prevention Program", dated 2017, revealed all facility staff shall participate and support the program through compliance with infection prevention practices, policies and procedures, reporting infection prevention concerns, and cooperation with the Infection Prevention Officer/Infection Prevention Committee as needed and required. Resident #28: On 10/08/19 at 2:45 PM, observation of catheter care for Resident #28 revealed Certified Nursing Assistant (CNA) #2 and CNA #1 washed their hands, applied clean gloves, and began care. When CNA #1 unfastened Resident #28's brief the resident did not have a securing device in place to either of his thighs. As Resident #28's trash can became full of soiled supplies, with her gloved hands CNA #1 pushed the overfilled trash slightly down in the trash can. CNA #2 placed the plastic bag that had the soiled pad in it and the	F 880	infection control, proper handling of trash and soiled linens by Staff Educator Registered Nurse. On 10/14/19-11/1/19, all Certified Nursing Assistants performed skills check offs on catheter care with Staff Educator Registered Nurse. Beginning 11/1/19, Staff Educator Registered Nurse will do skills check offs on catheter care with three Certified Nursing Assistants per week for four weeks then monthly for two months. On 10/14/19-10/25/19, all licensed nurses were in-serviced by Staff Educator Registered Nurse on infection control and proper handwashing. On 10/14/19-11/1/19, all licensed nurses will perform wound care skills check offs with Staff Educator Registered Nurse. Beginning 11/1/19, Staff Educator Registered Nurse will do wound care skills check offs with two licensed nurses per week for four weeks then monthly for two months. *Any discrepancies will be brought to Quality Assurance Committee monthly by Staff Educator Registered Nurse. The Quality Assurance Committee will make recommendations and/or changes as needed to ensure compliance.	

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 _____	10/10/2019

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 18	F 880		

resident's soiled pants on Resident #28's floor bedside his bed. After CNA #1 cleaned Resident #28, she placed the soiled pants in the plastic with the soiled pad and sat the plastic bag on the floor.

Record review of the physician orders, dated 9/27/19, indicated an order for a Foley Catheter to drainage, change catheter every (Q) month using routine catheter orders and catheter care instructions. An order for a leg bag during the day and large bag at night. An order, dated 9/19/19, for 16 French (FR) 10 Cubic Centimeter (CC) bulb indwelling Foley Catheter: Ensure Fig Leaf Bag in place for privacy, leg strap in place Q shift: Catheter bag should always be below the level of the bladder.

On 10/09/19 at 9:05 AM, an interview with CNA #1 revealed when she pushed the trash down in Resident #28's trash can, that caused cross contamination and when she sat the plastic bag on the resident's floor, that was an infection control problem.

On 10/09/19 at 9:10 AM, an interview with CNA #2 revealed when she sat the plastic bag on Resident #28's floor, that was an infection control issue.

On 10/09/19 at 9:36 AM, an interview with the Director of Nursing (DON) revealed when CNA #1 sat the plastic bag on Resident 28's floor and pushed the trash down in the trash can, that is an infection control issue. She also stated when CNA #2 sat the plastic bag on the resident's floor that is an infection control issue.

On 10/09/19 at 9:54 AM, an interview with

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 _____	10/10/2019

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 19	F 880		

Registered Nurse (RN) #2 revealed CNA #1 and CNA #2 putting the plastic bag on the floor was an infection control issue.

On 10/09/19 at 10:05 AM, an interview with RN #1 revealed when CNA #1 and CNA #2 sat the plastic bag on the resident's floor, that causes cross contamination and is an infection control issue.

Resident #45
On 10/07/19 at 2:43 PM, an observation revealed Registered Nurse (RN) #3 washed her hands and applied clean gloves, then she opened a catheter kit, removed her glasses from her top left uniform pocket, put her glasses on, opened the catheter tubing, and opened the sterile gloves. After RN #3 inserted the suprapubic catheter, she washed her hands, applied clean gloves, opened the leg bag, and laid it on the resident's over-bed table, without a barrier. She then left Resident #45's room to get some scissors, returned to the resident's room, washed her hands and applied clean gloves. RN #3 cut some of the catheter drainage tubing off, then connected the drainage tubing the catheter tubing, removed her gloves, opened the securing device and applied the securing device to the drainage bag.

On 10/9/19 at 10:05 AM, an interview with RN #1 revealed when RN #3 removed her glasses from her uniform pocket with her gloved hands and continued to set up her supplies, that was an infection control issue. She also stated when RN #3 sat the drainage bag on the resident's over-bed table without a barrier, that was an infection control issue.

On 10/10/19 at 12:05 PM, an interview with RN

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 _____	10/10/2019

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 20 #5 revealed she would expect the nurse to use aseptic technique when providing care. On 10/10/19 at 12:16 PM an interview with RN #3 revealed, when she removed her eyeglasses from her left uniform pocket, that was cross contamination and when she sat the urinary drainage bag on the resident's over-bed table without a barrier, that was cross contamination. Resident #37 Review of the 9/16/2019 Physician Orders for Resident #37, revealed: Cleanse Stage three (3) Pressure Ulcer to Sacrum with Normal Saline, Pat Dry, Apply Collagen (lightly dampen with Normal Saline) cover with Opti foam every Monday, Wednesday, and Friday until healed. Observation on 10/08/19 at 2:54 PM, revealed Registered Nurse (RN) #3, performed wound care on Resident #37 per physician orders. RN #3 placed a barrier, prepared supplies, washed hands and donned gloves. RN #3 removed the dirty dressing, cleaned wound with Normal Saline, applied Collagen and covered the wound per orders. RN #3 removed gloves, and washed hands at the end of the procedure. On 10/09/19 at 10:32 AM, an interview was conducted with RN #3 on speaker phone, with the Director of Nursing (DON) present. RN #3 confirmed she only washed her hands at the beginning of the procedure, but did not wash her hands or don gloves from dirty to clean. RN #3 revealed not washing her hands from dirty to clean could cause both infection control issues and cross contamination. The DON confirmed by RN #3 not washing her hands and keeping the same gloves on during the entire procedure,	F 880		

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 _____	10/10/2019

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 21 could cause both infection control issues and cross contamination. On 10/09/19 at 2:52 PM, an interview with RN #2, Infectious Control Registered Nurse, revealed by RN #3 not washing her hands from clean to dirty of dressing change, and not changing gloves after removing dirty dressing, may cause cross contamination and infection control issues. On 10/09/19 at 3:00 PM, an interview with the Staff Development Coordinator, revealed the procedure of wound care performed on Resident #37, by RN #3, revealed not washing hands or changing dirty gloves after dirty dressing removal, may cause cross contamination and infection control issues.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255310	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/11/2019**

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
K 000	INITIAL COMMENTS 42 CFR 483.70 (a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, the facility failed to properly insure the operability of the sprinkler system as required by NFPA 25 Table 2-1and NFPA 25 section 5.2.1.2. This condition affected one (1) of three (3) compartments in the facility on the day of survey.	K 353	*On 10/31/19, facility has contacted a licensed vendor to replace all corroded and rusted sprinkler heads in the kitchen of the facility. *All residents of the facility have the potential to be affected by this deficient	11/25/19

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

Electronically Signed | 11/01/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255310	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/11/2019**

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
K 353	Continued From page 1 Findings include: On October 11, 2019 at 10:10 AM, observation revealed corroded and rusty sprinkler heads in the Kitchen of the facility. The sprinkler heads were obstructed and unable to discharge water upon activation of the fire sprinkler system.	K 353	practice. *On 10/31/19, maintenance technician was in-serviced by regional vice president on the importance of inspecting sprinkler heads throughout facility on a routine basis and the use of "Sprinkler System Inspection Log" to document these inspections. All sprinkler heads throughout the facility will be inspected weekly for three months then monthly thereafter for corrosion, dust, or obstruction. Any problems noted will be corrected by maintenance technician or outside licensed vendor. *Sprinkler System Inspection Log will be brought to Quality Assurance Committee by maintenance technician for review and monitoring quarterly. Any discrepancies will be brought to the administrator for corrective action. *Technicians for contracted company to replace all sprinkler heads noted with rust or corrosion will be in facility on 11/8/19. All sprinkler heads with rust or corrosion will be replaced on 11/8/19.	

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 _____	10/11/2019

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
E 000	Initial Comments ********** Survey conducted on 10/11/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

Electronically Signed | 11/01/2019

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.