STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	255310	A. BUILDING: _____ B. WING _____	11/22/2022

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 842	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	255310	A. BUILDING: _____ B. WING _____	11/22/2022

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 842	Continued From Page 1

(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on interviews, record reviews, and facility policy review, the facility failed to ensure a medical record was accurately documented as evidenced by the clinical record of a resident did not have a written order to transfer the resident to a behavioral health facility for one (1) of 15 residents reviewed. Resident #41

Findings Include:

A review of the facility's policy, "Physician Order Review", dated 01/09/15 revealed, " ...Policy ...It is the policy of this facility that the Q.A. (Quality Assurance) nurse will periodically review the physician's orders as follows: To insure proper documentation ...Any problems noted will be reported to the Director of Nursing ..."

A record review of "Departmental Notes" revealed a "Social Services" note for Resident #41, dated 09/20/22 at 9:05 AM for, "SS (Social Services) obtained verbal consent from (Proper Name of Resident Representative) to be admitted to (Proper Name of Behavioral Health Unit)".

A record review of the clinical record revealed there was no written physician's order to transfer Resident #42 to the behavioral health unit of a hospital on 09/20/22.

On 11/22/22 at 04:26 PM, in an interview with the Director of Nursing (DON), he stated that Resident #41 was planned to be discharged from the facility to home on 09/22/22. However, things "went wild" on 09/20/22 and the Medical Director gave a verbal order to send the resident to a psychiatric hospital. He commented that the "ball must have gotten dropped" on entering the verbal order into the computer.

On 11/22/22 at 04:41 PM, in an interview with the Administrator, he stated that he expected all verbal physician orders to be added to the medical record in a timely manner.

A review of the "Face Sheet" revealed the facility admitted Resident #41 on 08/17/22 with diagnoses including Bipolar Disorder and Type 2 Diabetes Mellitus.