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 _____	11/22/2022

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 re-certification survey at the facility from 11/20/22 to 11/22/22. During the survey, the SA determined that the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited deficiencies F759, F761, and F842. The facility was licensed for 55 beds and had a census of 45 at the time of the survey.	F 000		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interviews, facility policy review, and record review, the facility failed to maintain a medication error rate below 5 percent (%) for two (2) of 25 medication opportunities, resulting in an 8% medication error rate. Findings include: Review of the facility's policy, "Medication Administration", with a revision date of 11/12/21, revealed, " ... Medication Administration Record (M.A.R.) shall be compared with physician orders prior to preparation of any medications. The individual administering the medication shall verify the medication and be aware of the following information concerning each medication route and frequency of administration: ...Route	F 759	F759 1. Immediate action(s) taken for the resident(s) found to have been affected include: License Practical Nurse #1 failed to follow physician order related to medication administration. License Practical Nurse #1 was in serviced on 11/30/22 by the Staff educator on the importance of administering medications per physician orders. 2. Identification of other residents having the potential to be affected was accomplished by: All residents' medications have the potential to be affected by this practice. 3. Actions taken/systems receiving put	12/30/22

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

Electronically Signed | 12/14/2022

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F 759	Continued From page 1 and frequency of administration ..." On 11/21/22 at 9:45 AM, observed Licensed Practical Nurse #1 (LPN) administer a Baclofen 5 milligram (MG) tablet and 20 milliliters (ML) of Tegretol suspension to Resident #2 per percutaneous endoscopic gastrostomy (PEG) tube. Record review of the active orders for Resident #2 on the "Physician Orders List," revealed orders for Baclofen 5 MG tablet: Give one tablet PO (by mouth) TID (three times a day) and Tegretol 100 MG/5ML suspension: Give 20 ML to equal 400 MG PO TID. Record review of the "Face Sheet" of Resident #2 revealed an admission date of 2/24/16. The resident's diagnoses include Dysphagia unspecified and Cerebral Palsy. Record review of the Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 9/5/22 for Resident #2 revealed a Brief Interview of Mental Status (BIMS) score of 03, which indicated severe cognitive impairment. On 11/21/22 at 3:05 PM, in an interview with LPN #1 she confirmed she made a mistake and should have given Resident #2 his medication by mouth as ordered. She explained that administering the medications by the wrong route, could cause adverse effects. On 11/21/22 at 3:40 PM, in an interview with the Director of Nursing (DON), he stated that LPN #1 should have followed physician orders. The DON revealed that administering the medication through the PEG tube could cause an absorption problem for the resident. The DON stated he	F 759	into place to reduce the risk of future occurrence include: An in-service was initiated for all nursing staff on preventing medication errors on 12/2/22 by the Staff Educator. The Staff educator-initiated audits for all nurses individually on 12/2/22. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Medication administration audits began on 12/12/22 and will be conducted for three nurses weekly for four weeks, then two nurses monthly for (3) months, then one nurse monthly on-going to ensure compliance with facility guidelines. Audit results will be reviewed by the Quality Assurance Committee, beginning the December Quality Assurance meeting and subsequent weekly Quality Assurance meetings for four weeks, to discuss the findings prior to final completion. Corrective action completion date: December 30, 2022	

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F 759	Continued From page 2 expects the nurses to follow Physician orders.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record reviews, and facility policy review, the facility failed to remove expired Pneumovax-23 (pneumococcal vaccine polyvalent) vials from the medication storage refrigerator for one (1) of one (1) medication rooms observed.	F 761	F761 Immediate action(s) taken for the resident(s) found to have been affected include: All seven Pneeumovax-23 vials were removed from the medication storage refrigerator and discarded by Director of	12/30/22

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F 761	Continued From page 3 Findings include: Review of the facility's policy, "Safe Medication Practices" with a revision date of 7/31/15, revealed, " ...Ensure expiration date is within defined limits ..." On 11/20/22 at 3:45 PM, an observation of the medication storage room with Licensed Practical Nurse (LPN) #2 revealed seven (7) Pneumovax-23 vials in the medication storage refrigerator with an expiration date of 10/12/22. On 11/20/22 at 4:00 PM, in an interview with LPN #2, she confirmed it is the responsibility of the nursing staff to remove expired medications from the medication storage refrigerator. She stated expired vaccines should not be given to a resident, as they could be less effective. On 11/20/22 at 4:08 PM, in an interview with LPN #3/Charge Nurse, she explained the nurses on the night shift are responsible for checking expiration dates of medications in the storage room and removing them. She stated if a resident is given expired medication, depending on the medication, the medication could be less effective, or the resident could have an adverse reaction. She confirmed that there were seven (7) vials of Pneumovax-23, with an expiration date of 10/12/22, that should have been removed. On 11/22/22 at 2:45 PM, in an interview with the Director of Nursing (DON), he revealed checking for expired medications are part of the assigned duties to the nursing staff working at night. The DON confirmed that expired Pnemovax-23 can be less effective, and the resident could still develop pneumonia.	F 761	Nursing on 11/20/22. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents receiving medications requiring refrigeration have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service education program was initiated by the Staff Educator with staff nurses on 12/2/22 addressing the facility policy regarding the proper storage of medications. How the corrective action(s) will be monitored to ensure the practice will not recur: In-service for all nurses was initiated on 12/2/22 by the Staff Educator and findings will be discussed in the December Quality Assurance committee meeting. The Unit managers and Quality Assurance Nurses will inspect the medication storage refrigerator 3 times a week, beginning on 12/12/22, for four (4) weeks and findings will be discussed in weekly Quality Assurance meetings for four weeks. Subsequent weekly inspections will be conducted for three (3) months to ensure there are no expired medications and appropriate storage on an on-going basis. Corrective action completion date: December 30, 2022	

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