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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 41680 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 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 an interview with Registered Nurse (RN) (continued on next page)

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.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#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.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 44179 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 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 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. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 41680 Based on staff and resident interviews, record reviews, and facility policy review, the facility failed to ensure dependent residents received the 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) #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).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41680 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 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.