Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CROSS HEALTH & REHAB	**503 SILVER CROSS DRIVE , BROOKHAVEN, Mississippi, 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
M0000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 10/20/2025 through 10/22/2025. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and cited M1570.	M0000		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, interviews, record reviews and policy review the facility failed to prevent the possibility of the spread of infection though a	M1570		

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

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M1570	Continued from page 1 Peripherally Inserted Central Catheter (PICC) line for one (1) of three (3) medication administrations observed. Resident #11. Findings include: A record review of the facility's "Medication Administration" policy with a revision date of 6/8/23 revealed "Medications are administrated by licensed nurses or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice in a manner to prevent contamination or infection... 18.Wash hands using facility protocol ..." On 10/22/25 at 10:08 AM an observation of Registered Nurse #11(RN) hanging Vancomycin via intravenously (IV). RN entered room with a gown in place and explained to Resident #11 that she was going to administer Vancomycin via IV. She knocked on the door and placed a Styrofoam tray on bedside with supplies on it. When she entered the room, she performed hand hygiene. She applied gloves to hands. She closed the privacy curtain with gloves on. She inserted tubing into the vancomycin and primed tubing. She flushed PICC line with normal saline. She dropped a top on the floor, picked it up and changed glove without performing hand hygiene. She applied clean gloves and connected tubing to the PICC line and turned the IV pump on. She removed gloves and the gown, sanitized hands and exited the room. On 10/22/25 at 10:15 AM in an interview with RN #11 confirmed that she did not wash her hands before and between administering vancomycin through PICC line. She stated she forgot to wash her hands. She stated that by not washing hands and administering medication through PICC line the resident could get an infection in the PICC line. On 10/22/25 at 11:13 AM in an interview with Director of Nursing (DON) stated RN told him she got nervous and forgot. He stated RN #1 should wash her hands before starting care. He stated nurses should wash hands after picking up a top off the floor and applying clean gloves. He stated she put the resident at risk for contaminating the PICC line and could possibly lead to the resident getting an infection. On 10/22/25 at 11:50 PM in an interview with Licensed Practical Nurse #1 (LPN)/ Infection Preventionist (IP) nurse stated RN #1 should have washed hands prior to entering the room. She stated after closing curtain she should have removed gloves and performed hand hygiene	M1570		

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M1570	Continued from page 2 and applied clean gloves. When she picked up top off the floor she should remove gloves and do hand hygiene. She stated the resident was put at risk for PICC line infection. On 10/22/25 at 12:31 PM an interview with DON stated the expectations are that nurses follow physician orders and make sure infection control is followed. A record review of Resident #11 “Admission Record” revealed an admission date of 10/9/25 with diagnosis of acute Osteomyelitis right ankle and foot, Cellulitis of right lower limb, Acute kidney failure and chronic kidney disease stage 4 (severe). A record review of Resident #11's Order Summary Report revealed an order dated 10/9/25 for Vancomycin HCl Intravenous Solution use 1,000 mg (milligrams) intravenously one time a day related to osteomyelitis right ankle right foot. Cellulitis of the lower right limb for 42 days.	M1570		