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	12/11/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and policy review, the facility failed to maintain a safe, functional, and homelike environment for residents in a common area, Specifically, the facility failed to repair missing floor tiles in the dining room, a high-traffic area for four (4) out of 4 days of survey.Findings include:A review of the facility's Resident Rights policy revealed, The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.On 12/08/2025 at 12:10 PM, chipped and partially missing floor tiles were observed in the front right section of the dining room.On 12/09/2025 at 12:05 PM, during the lunch dining period, the chipped and missing tiles remained unrepaired.On 12/10/2025 at 2:11 PM, chipped and missing tiles were again observed in the dining room common area for the third consecutive day of the recertification survey.On 12/10/2025 at 12:24 PM, in an interview with the Maintenance Director, he stated that chipped tiles could cause a tripping hazard and that he attempts to glue tiles down as needed when he notices they become loose or missing. He acknowledged that he was unaware of the currently missing tiles in the dining room and stated that no work order had been submitted.On 12/10/2025 at 4:15 PM, during an interview with the Director of Nursing (DON), he stated that the area with missing tiles could pose a tripping hazard. He acknowledged that Certified Nursing Assistants and nurses are routinely present in the dining room during meals and could have submitted a work order. He stated that the area with missing tiles was typically covered by a long table, and the issue may have only been recently visible due to the placement of a Christmas tree.On 12/11/2025 at 11:25 AM, chipped tiles continued to be observed in the same area for the fourth consecutive day of survey.On 12/11/2025 at 1:03 PM, in an interview with the Nursing Home Administrator (NHA), he stated that the Maintenance Supervisor provides new staff with orientation on submitting work orders for environmental concerns. However, he confirmed there was no formal policy in place to address environmental safety hazards such as chipped or missing flooring.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to ensure food items were stored under sanitary conditions by not removing expired food from the dry storage area for one (1) of three (3) observation days. This failure had the potential to result in foodborne illness for residents consuming food from the kitchen. Findings Include:A record review of the facility's First IN First Out (FIFO) policy undated revealed a product rotation is important for both quality and safety reasons. FIFO means that the first batch product prepared in storage should be used first. Identify the food items use by or expiration date. Throw out food that has passed its manufacturers use or expiration date.On 12/8/25 at 10:20 AM an initial tour of the kitchen revealed the following items were expired and found in the dry storage room: Honey grade A five (5) ounces opened 12/9/24 expiration 10/10/25. There were 5 bottles of lemon juice that expired on 4/5/25. There were two gallons of Monarch Italian dressing expiration 10/2/25.On 12/8/25 at 11:08 AM in an interview with the Dietary Manager (DM) stated the cook is responsible for pulling expired food. She stated the staff should rotate items when putting up stock. She stated it is her responsibility to make sure staff do their job. She stated expired foods could make residents sick.On 12/11/25 at 3:14 PM in an interview with the Nursing Home Administrator (NHA) stated he expects staff to monitor daily and staff to pull all foods expired.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, facility policy review, and record review, the facility failed to ensure one (1) of four (4) sampled residents (Resident #25) was treated with dignity and respect by staff during care and communication. Findings Include:A record review of the facility Resident's Rights policy revealed the resident has a right to be treated with respect and dignity.On 12/10/25 at 4:30 PM, in an interview with Licensed Practical Nurse (LPN) # 4, she stated there had been concerns raised regarding a nurse, LPN #3, who was reported for interactions with multiple residents, including Resident #25 and Resident #11, and who often works the A hall. LPN 4 described the issue as related to tone and arguing with residents.On 12/11/25 at 9:01 AM, in an interview with Resident #25, he stated that LPN # 3, who works the night shift, talks to him in a loud and gruff tone, which he compared to a police officer. He reported she does not threaten residents but does not speak to them in a respectful or dignified manner.On 12/11/25 at 9:15 AM, in an interview with the Director of Nursing (DON), he confirmed that a recent complaint had been investigated regarding LPN #3 although it was unsubstantiated. He stated that while her tone is structured, there had been no formal complaints related to her communication style.On 12/11/25 at 9:30 AM, in an interview with Resident #11 she described LPN # 3 as someone who often argues with Resident # 25 and raises her voice, stating that she likes to be loud and get smart with him, especially when the resident calls the nurse baby and she argues with him loudly and tells him not to call her that.On 12/11/25 at 11:10 AM, in an interview with LPN # 3, she stated she had never received formal complaints but acknowledged that she had been in-serviced recently regarding tone due to residents not being able to hear her, leading her to raise her voice at times. She admitted redirecting residents like Resident #25 who call her pet names such as sugar by asking them to use her name instead.A record review revealed Resident #11 admission Record revealed was admitted on [DATE] with diagnoses including hemiplegia and hemiparesis.Record review of Resident #11's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/27/25 revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating cognitive intactness.A record reviewed of Resident #25 admission Record revealed he was admitted on [DATE] with a diagnosis of Chronic Diastolic Congestive Heart Failure.Record review of Resident #25's MDS with an ARD of 11/17/25 revealed a BIMS score of 15 indicating no cognitive impairment.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, facility policy review and record review, the facility failed to ensure that one (1) of three (3) residents (Resident #8) assessed as moderately cognitively impaired was properly evaluated for the safe self-administration of medication. Findings Include:A record review of the facility's policy, Self-Administration of Medication and Bedside Medication with a revised date of 3/10/25 revealed this facility's policy is that residents may self-administer their medications given the approval of the interdisciplinary or care planning team. A resident may administer his/her own medications if the disciplinary team determines that this practice is safe. A Self-Administration evaluation should be completed in the Electronic Health Record. (EHR)On 12/08/2025 at 4:13 PM an observation and interview revealed Resident #8 with a 3.5-ounce jar of Vapor Rub on his bedside table . Resident #8 stated he uses it as he needs it and he brought it from home. He stated he rubs it under his nose. He stated staff do not know when he uses it but he was using it at home.On 12/09/2025 at 2:50 PM in an interview and observation of Resident #8 with the Director of Nursing (DON) the Vapor Rub remains on the bedside table. Resident #8 stated I use that on my nose when I have a cough or cold. On 12/09/2025 at 3:18 PM in an interview with the DON he stated Resident #8 should not have Vapor Rub at bedside. He stated that for a resident to self-administer medications there are multiple assessments that should be completed. He stated he can have inhalation issues by using it on his own and breathing it in his nares. He confirmed Resident #8 has not had any self-administration of medication assessments done.A record review of Resident #8's admission Record revealed an admission date of 10/23/25 with diagnoses including Vascular Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance and Anxiety, and Primary open-angle Glaucoma, right eye, moderate stage.A record review of Resident #8's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/29/25 revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicates moderately impaired cognition.A record review of Resident #8's Physician Orders revealed there was no order for Vapor Rub.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to ensure accurate and complete documentation of advance directive status for one (1) of seventeen (17) sampled residents, Resident #5. Findings include: A record review of the admission Record revealed the facility admitted Resident #5 on 3/25/25 and she had diagnoses including Type 2 Diabetes Mellitus. A record review of the Acknowledgement of Advance Directives Decisions, Rights, and Information, signed by the resident representative (RR) and dated 3/25/25, indicated, I have formulated the following advance directives before admission to this facility. There was no indication as to what type of advance directive was formulated and there was also an x indicating I decline to formulate an Advance Directive at this time. On 12/09/2025 at 10:42 AM, in an interview with the Admissions Coordinator/Staff Scheduler, she stated she had searched for to see if any type of Advance Directive was provided to the facility. She was unable to find a copy and stated that she believed the RR initialed the form indicating an Advance Directive was formulated was done in error. On 12/10/2025 at 11:06 AM, in an interview with the Director of Nursing (DON), she stated the Acknowledgement of Advance Directives Decisions, Rights, and Information had been corrected on 12/9/25 and Resident #10 did not have an Advance Directive. On 12/11/2025 at 1:30 PM, in a joint interview with the Administrator and the Admissions Coordinator/Staff Scheduler, the Administrator stated that they were in the process of changing the Advance Directive form to make it more user friendly and less confusing.

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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. Based on observation, interview, facility policy review, and record review, the facility failed to implement the care plan interventions related to hearing needs and activity of daily living (ADL) needs for one (1) of 17 sampled residents (Resident #10). Specifically, the facility failed to follow up on a June 2025 audiology appointment that documented the need for further evaluation, failed to ensure the resident had functional hearing aids per her preferences and needs, and failed to coordinate care in accordance with the resident's care plan and physician orders.Findings Include:A record review of the facility's policy, Comprehensive Plan of Care with a revision date of 2/17/25, revealed it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident consistent with residents rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing.needs and all services that are identified in the residents comprehensive assessment and professional standards of quality.A record review of Resident #10 Comprehensive care plan revealed interventions to refer to audiology for hearing consult and assist with all ADL's and personal hygiene needs every shift and as needed.Observation and interview on 12/08/2025 at 2:11 PM Resident #10 has a moderate amount of grey hair under her chin and upper lip. She confirmed that she does not like the hair on her face. She stated that if she is lucky, they will shave her twice a week. She stated she was shaved early last week. She wants to be shaved every other day. An interview with Certified Nursing Assissant #1(CNA) on 12/10/2025 at 10:49 AM confirmed that Resident #10 had a moderate amount of facial hair and had not been shaved in days. She stated the resident has expressed to her that she does not like the facial hair on her face and wants it shaved.An interview with the Director of Nursing (DON) on 12/10/2025 at 3:32 PM stated that Resident #10 should be shaved when it is needed. He expects staff to do Activities of Daily Living (ADL) care daily. In an interview on 12/08/2025 at 2:00 PM Resident #10 stated she needs her new hearing aids. She stated she went to a doctor five months ago and still does not have new hearing aids. She stated they took her to a Miracle Ear Physician in a nearby city.An interview with Social Worker (SW) on 12/10/25 at 4:13 PM confirmed that Resident #10 was sent out to a nearby city for hearing evaluation in June. She stated she does not have the visits summary and will have to call to get it faxed over.On 12/11/25 at 11:15 AM an interview with DON stated Resident #10 was sent to Miracle Ear at her request. He stated if the physician office sends a summary, it would be bought back CNA #2 Transportation Aid. He stated sometimes the physician will fax summaries. He stated a CNA or nurse could get the summary if it does not come back with transportation. He confirmed that no one had followed up with getting the physician summary.A record review of Resident #10 Appointment Summary dated 6/3/25 from her hearing aid supplier revealed Outcome results: Needs further evaluation. Outcome Notes: impacted. The patient brought aids in they were stopped up. Cleaned and changed domes. Patient hearing better. Will get ears cleaned out and come back when she can.On 12/11/25 at 12:29 PM in an interview with CNA #2 /transportation stated she took resident to her Miracle Ear appointment. She stated she goes back with resident for appointment to make sure nothing is missed. She stated when the summary is given to her, she gives it to the Unit Manager. She stated she was informed by physician that Resident #10 ear and hearing aid was packed with wax. She was not given the summary to bring back. She stated she makes follow up appointments and if knew she would have made appointment for evaluation.On 12/11/25 at 2:04 PM in an interview with Registered Nurse #2/Care Plan Nurse stated the care plan is used by all staff for providing care. The care plan lets staff know preferences. She stated that if ADL is not done the care plan was not followed. She further stated the care plans also revealed need further evaluation by the Audiologist and if it was not done after the Audiologist visit in June, then care plan was not followed. On 12/11/2025 at 2:09 PM in an interview with the DON stated the physician at Miracle Ear should have followed up with the facility. He stated if he had known what the summary revealed he would (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have called the physician for clarity. A record review of Resident #10 admission Record revealed an admission date of 10/16/24 with diagnosis of Encounter for Prophylactic Measures, Unspecified and Vitamin D Deficiency Unspecified. A record review of the Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/9/25 revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicates 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. Based on observation, interview, facility policy review, and record review, the facility failed to ensure grooming needs were met in accordance with the resident's preferences and needs for one (1) of three (3) residents reviewed for activities of daily living (Resident #10). Specifically, the facility failed to provide facial shaving per resident request and failed to document refusal of care when shaving was not provided, resulting in unaddressed personal hygiene needs and potential negative impact on resident dignity. Findings Include:A record review of the facility's policy, Activities of Daily Living revised 9/16/22 revealed, .Care and services will be provided for the following activities of daily living: bathing, dressing, grooming, and oral care.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 care.On 12/08/2025 at 2:11 PM observation and interview of Resident #10 revealed a moderate amount of grey hair under her chin and upper lip. She confirmed that she does not like the hair on her face. She stated that if she is lucky, they will shave her twice a week. She stated she was shaved early last week. She revealed her preference is to be shaved every other day. On 12/10/2025 at 10:49 AM, an interview with Certified Nursing Assistant (CNA) #1 confirmed Resident #10 had a moderate amount of facial hair and had not been shaved in several days. CNA #1 stated the resident had expressed dissatisfaction with the facial hair and had requested to be shaved.On 12/10/2025 at 3:32 PM, an interview with the Director of Nursing stated Resident #10 should be shaved as needed. The Director of Nursing stated he expects staff to provide activities of daily living care on a daily basis.A record review of Resident #10's admission Record revealed an admission date of 10/16/2024 with diagnoses that included Depression Unspecified and Primary Osteoarthritis of the right shoulder.A record review of Resident #10 Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/9/25 revealed a Brief Interview of Mental Status (BIMS) score of 14, which indicates cognitively intact.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on observation, interview, facility policy review, and record review, the facility failed to ensure timely follow-up and coordination of care related to hearing needs for one (1) of three (3) residents reviewed for sensory impairment (Resident #10). Specifically, the facility failed to ensure the resident's hearing aids were functional, to act on evaluation results that indicated further follow-up was needed, and to implement or revise care plan interventions related to hearing loss. These failures resulted in the resident experiencing prolonged difficulty hearing and unmet sensory needs.Findings Include:A record review of the facility's Physician Order Review policy dated 1/9/15 revealed, Purpose: To ensure safety and comply with standards of care. To verify the necessity to initiate, continue or change appropriate treatments as ordered. To maintain appropriate continuity in resident care.On 12/08/2025 at 2:00 PM Resident #10 stated she needs her new hearing aids. She stated she went to a doctor five months ago and still does not have new hearing aids. She stated they took her to a Miracle Ear Physician in a nearby city.On 12/10/25 at 4:13 PM an interview with Social Worker (SW) confirmed that Resident #10 was sent out to a nearby city for hearing evaluation in June. She stated she does not have the visits summary and will have to call to get it faxed over.On 12/11/25 at 8:45 AM the Director of Nursing (DON) confirmed that they did not have appointment summary yet. He stated the Miracle Ear is requesting consent to fax summary.On 12/11/25 at 9:10 AM an interview with SW confirmed she had to get it faxed to the facility. She stated usually CNA aid brings the summary back when a resident goes out to an appointment.On 12/11/25 at 11:01 AM in an interview with SW stated Resident #10 went to a local hearing aid supplier. She stated she was sent out to them by resident request. She stated she was aware of resident hearing issues upon admission. She stated Certified Nursing Assistant #2 (CNA) is the Transportation Aide. She stated that usually transportation aid brings back the summary. The Unit Manager or Medical records request summaries if they are not brought back to the facility.On 12/11/25 at 11:15 AM an interview with the DON he stated Resident #10 was sent to the hearing aid supplier at her request. He stated if the physician office sends a summary, it would be bought back by CNA #2 Transportation Aide. He stated sometimes the physician will fax summaries. He stated a CNA or nurse could get the summary if it does not come back with transportation. He confirmed that no one had followed up with getting the physician summary. There is no specific person that gets the summary from physician offices and follows up.On 12/11/25 at 12:29 PM in an interview with CNA #2 /Transportation stated she took Resident #10 to her hearing aid appointment. She stated she goes back with resident for appointment to make sure nothing is missed. She stated when the summary is given to her, she gives it to the Unit Manager. She stated she was informed by physician that Resident #10 ear and hearing aid was packed with wax. She was not given the summary to bring back. She never was given the summary or made aware of the follow-up appointment. She stated if she knew she would have made appointment for evaluation.On 12/11/2025 at 2:09 PM in an interview with the DON stated the physician at the hearing aid supplier should have followed up with the facility. He stated if he had known what the summary revealed he would have called the physician for clarity.A record review of Resident #10 admission Record revealed an admission date of 10/16/24 with diagnosis of Encounter for Prophylactic Measures, Unspecified and Vitamin D Deficiency Unspecified.A record review of the Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/9/25 revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicates cognitively intact.A record review of Resident #10 Appointment Summary dated 6/3/25 from her hearing aid supplier revealed Outcome results: Needs further evaluation. Outcome Notes: impacted. The patient brought aids in they were stopped up. Cleaned and changed domes. Patient hearing better. Will get ears cleaned out and come back when she can.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident received care consistent with professional standards of practice and physician orders for the treatment of a pressure ulcer for one (1) of three (3) residents reviewed for pressure ulcers (Resident #38). Findings Include:Record review of Resident #38's physician orders revealed an order dated 12/10/25 to cleanse the Stage 3 pressure ulcer to the coccyx with normal saline, pat dry, apply Medi-Honey to the wound bed, place calcium alginate over the honey, and cover with border foam dressing daily.On 12/10/2025 at 10:58 AM, wound care was observed being administered to Resident #38 by Registered Nurse (RN) #1 with the assistance of Licensed Practical Nurse (LPN) #1. During the procedure, RN #1 applied Zinc Oxide ointment around the edges of the wound after completing the ordered wound care.On 12/10/2025 at 11:15 AM, during an interview RN #1 verified that Zinc Oxide was not listed as an active order for Resident #38 on the Medication Administration Record (MAR).On 12/10/2025 at 12:40 PM, during an interview with the Director of Nursing (DON), he confirmed that medical orders must be followed as written and that the addition of Zinc Oxide without a physician's order did not align with the established wound care plan.Record review of admission Record revealed that Resident #38 was admitted on [DATE] with diagnoses that included cerebral infarction, hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting the left dominant side, and a Stage 3 pressure ulcer of the sacral region. Record review of Resident #38's Minimum Data Set (MDS) with an Assessment Reference date of 10/16/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident is cognitively intact.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure that professional nursing standards were followed during percutaneous endoscopic gastrostomy (PEG) tube care for one (1) of one (1) resident (Resident #44) reviewed for enteral nutrition. Findings Include:On 12/10/2025 at 10:00 AM in an observation of Registered Nurse #1 (RN)/Wound care provide peg tube care to Resident #44, she cleaned the PEG site with a gauzed soaked in wound cleaner. She cleaned the site using the same gauze in a circular motion four times without discarding and replacing it with a new gauze for each wipe, as per infection control standards. On 12/10/2025 at 10:12 AM in an interview with RN #1 stated she should have discarded the gauze and got another one while cleaning the site. She stated it could cause Resident #44 to get an infection. If infection is at the site, it could have spread the infection.On 12/10/2025 at 3:35 PM in an interview with the Director of Nursing (DON) stated that RN#1 should have wiped once and discarded gauze with each wipe. She should not have continuously wiped in circular motion that could cause infection around the PEG site, skin irritation, and discomfort to the resident.A record review of Resident #44 admission Record revealed an admit date of 1/5/24 with diagnosis of Hemiplegia and Hemiparesis following other Nontraumatic Intracranial Hemorrhage affecting Right Dominant side and Dysphagia following other Non-traumatic Intracranial Hemorrhage.A record review of Resident #44 Physician orders revealed cleanse PEG tube site with wound cleanser and pat dry, apply sure prep topically under and around peg tube, cover with drain sponge, and secure with paper tape and as needed.A record review of Resident #44 Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/29/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicates cognitively intact.A record review of RN #1 Licensed Nurse Competency revealed she was checked off on PEG tube management by lecture and direct observation on 6/25/25.

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	12/11/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility policy review, and record review, the facility failed to maintain appropriate infection prevention and control practices during enteral medication administration for one (1) of three (3) residents reviewed for infection control concerns (Residents #27). Findings Include: A record review of the facility's policy Infection Prevention and Control Program with a revision date of 2/17/25 revealed this facility has established and maintains 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 as per accepted national standards and guidelines .11. Equipment Protocol: a. All reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment. Resident #27: On 12/10/25 at 1:04 PM, Licensed Practical Nurse (LPN) #5 was observed administering Percutaneous Endoscopic Gastrostomy (PEG) tube meds to Resident # 27, at this time, the nurse took the syringe apart to drain meds into the stomach by gravity with the peg tube and placed the syringe plunger onto the bedside table next to other household items without laying it on clean barrier or disinfecting the table. After the task was completed, the nurse rinsed the syringe with water and placed it back into the resident's zip lock bag on the bedside pole and exited the room. In an interview on 12/10/25 at 1:07 PM LPN #5 was asked if a barrier should have been used to place the syringe on, she stated yes, to prevent from spreading infections to the resident. She stated she rinsed it so it should have been okay. When asked if she used soap and water, she said no but she patted it dry. LPN #5 was asked if she thought this was sufficient to clean the bacteria off from the bedside table before another nurse uses it for a feeding and she said no, I'll get a new syringe for the resident. On 12/10/25 at 2:52 PM in an interview with the Infection Preventionist LPN #2, she stated that the plunger of the PEG tube syringe should not have been placed on a surface such as the bedside table without a barrier due to it being a contaminated surface and not knowing what is on that surface. It could spread infection and cause possible infection to the resident since the syringe directly goes into the stomach, she stated the nurse should have replaced the syringe and not placed it back on the pole for someone else to come by and use later. At 10:05 AM on 12/11/25 in an interview with the Director of Nursing (DON), he stated that a barrier should have been laid down between the syringe plunger and the table and it should have been properly cleaned or disposed of and a replacement obtained in this situation since it was contaminated. A record review of the admission Record revealed Resident #27 was admitted on [DATE] with a diagnosis of Parkinson's Disease. A record review of the most recent Minumum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/10/25 revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated a mild cognitive impairment.