| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 255279 | A. BUILDING _____ B. WING _____ | 07/23/2024 |

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| SARDIS COMMUNITY NH | 613 EAST LEE STREET SARDIS, MS 38666 |

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| F 000 | INITIAL COMMENTS<br><br>The State Agency (SA) conducted an annual re-certification survey at the facility from 7/22/24 to 7/23/24. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F640, F656, F677, and F699.<br><br>The census at the time of the survey was 56 and the facility is licensed for 60 beds. | F 000 | | |
| F 640 SS=D | Encoding/Transmitting Resident Assessments<br>CFR(s): 483.20(f)(1)-(4)<br><br>§483.20(f) Automated data processing requirement-<br>§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:<br>(i) Admission assessment.<br>(ii) Annual assessment updates.<br>(iii) Significant change in status assessments.<br>(iv) Quarterly review assessments.<br>(v) A subset of items upon a resident's transfer, reentry, discharge, and death.<br>(vi) Background (face-sheet) information, if there is no admission assessment.<br><br>§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.<br><br>§483.20(f)(3) Transmittal requirements. Within | F 640 | | 9/6/24 |

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

Electronically Signed | 08/06/2024

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| F 640 | Continued From page 1<br>14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:<br>(i)Admission assessment.<br>(ii) Annual assessment.<br>(iii) Significant change in status assessment.<br>(iv) Significant correction of prior full assessment.<br>(v) Significant correction of prior quarterly assessment.<br>(vi) Quarterly review.<br>(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.<br>(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.<br><br>§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interview, and facility policy review, the facility failed to complete and submit a Discharge Tracking Minimum Data Set (MDS) resident assessment to the Centers for Medicare and Medicaid Services (CMS) for a resident who transferred to an acute care facility for one (1) of 16 MDS's reviewed. Resident # 38.<br><br>Findings Include:<br><br>Review of the facility policy titled "MDS Process" with a revision date of 12/20 revealed, "The RAI (Resident Assessment Instrument) is the source document to be used for further MDS coding guidelines, time schedules and requirements." | F 640 | On 7/23/24 at 3:25 p.m. the Minimum Data Set (MDS) Nurse completed the discharge tracking assessment for resident #38.<br><br>All residents have the potential to be affected by this deficient practice.<br><br>An in-service on the facility policy and procedure for "MDS Process" was completed by the Staff Development Nurse for the MDS nurse on 7/23/24 at 3:30 p.m. The MDS nurse and Director of Nurses (DON) audited 100% of all residents who were discharged from the | |

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| F 640 | Continued From page 2<br><br>Record review of the "Progress Notes" revealed Resident #38's was transferred to a behavioral health center on 6/25/24 and returned to the facility on 7/9/24.<br><br>Record review of Resident #38's MDS Assessments revealed a discharge tracking assessment was not completed after Resident #38 was transferred to a behavior health center.<br><br>An interview with the Director of Nursing (DON) on 7/23/2024 at 2:45 PM, confirmed the MDS discharge tracking assessment for Resident #38 was not completed, and it should have been done.<br><br>An interview with the MDS Nurse on 7/23/2024 at 3:19 PM, confirmed Resident #38 did not have a discharge tracking assessment completed following the transfer to behavioral health. She revealed the facility was in the process of changing over charting systems at the time the assessment was due, and she missed it. She confirmed this should be done for tracking purposes.<br><br>Record review of the "Admission Record" revealed the facility admitted Resident #38 on 11/23/2021 and has diagnoses that include Senile degeneration of the brain. | F 640 | facility in the last 3 months to ensure that each of them had a discharge tracking assessment. Any and all discrepancies found were corrected immediately.<br><br>DON will audit all discharges weekly for the next 4 weeks, starting 8/5/24 and ending 9/5/24 and then monthly for the next 3 months and then quarterly. The DON will present her findings of her discharge tracking assessment audit to the Quarterly Quality Improvement (QI) meeting on 9/6/24 and then quarterly at each QI meeting until substantial compliance is achieved. I any negative findings occur with the current plan of correction, the QI committee will revise the plan of correction until compliance is obtained. | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the | F 656 | | 9/6/24 |

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| F 656 | Continued From page 3 | F 656 | | |

resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive

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| F 656 | Continued From page 4<br>care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, record review, and facility policy review, the facility failed to implement a care plan for nail and oral care (Resident #31) and failed to develop an individualized resident specific comprehensive care plan that identified potential fears, triggers, and/or behavioral expressions along with interventions for a resident with Post Traumatic Stress Disorder (PTSD) (Resident #37) for two (2) of 16 care plans reviewed.<br><br>Findings Include:<br><br>Record review of the facility policy, "Care Plan Process" with revision date of 08/17 revealed "...Step 9...The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs, including culturally competent and trauma-informed as well as, these items or services that would be required but are not due to the exercise of resident rights (refusal)...The facility staff shall follow the care plan..."<br><br>Record review of Resident #31's Care Plan, with no problem onset date, revealed "Resident has a dx (diagnosis) of Hemiplegia/Hemiparesis to right side ...Approaches ...Assist resident with ADLS (Activities of Daily Living) as needed ..."<br><br>On 07/22/24 10:00 AM, an observation of Resident #31 revealed he was lying in bed, alert, with his mouth open and his teeth had yellow | F 656 | 1. On 7/24/24 at 4:00 p.m. the Minimum Data Set (MDS) nurse completed an individualized care plan for Resident #31 including nail and oral care. Additionally, the MDS nurse completed an individualized care plan for Resident # 37 on 7/24/24 at 4:15 p.m. for Post Traumatic Stress Syndrome. Resident #31 and Resident # 37 care plans were audited by the DON to ensure that each of them were individualized for the highest practicable physical, mental, and psychosocial well-being of each resident on 7/24/24 at beginning at 8:00 a.m. any issues found were immediately corrected by the MDS nurse.<br><br>2. All 55 residents currently residing in the 60 bed facility that receive medical care have the potential to be affected by this deficient practice.<br><br>3. An in-service was completed by the Director of Nurses (DON) on facility policy, "Care Plan Process" with the MDS nurse and Registered Nurse (RN) Case Manager on 7/24/24 at 4:30 p.m.<br><br>Upon hire, annually and as needed all staff that are a part of the care plan process are trained on all aspects of the care plan process.<br><br>4. The DON will audit resident care plans during the weekly care plan meetings held | |

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| F 656 | Continued From page 5<br>substance covering all teeth. Observation also revealed brown substance under the fingernails of his left hand.<br><br>On 07/23/24 at 9:45 AM, an observation with Licensed Practical Nurse (LPN) #1, revealed Resident #31 lying in bed with a yellow substance covering his teeth and a brown substance under the fingernails of his left hand. LPN #1 confirmed that Resident #31 had yellow buildup on his teeth and revealed this could cause tooth decay and other problems with his mouth.<br><br>On 07/23/24 at 12:30 PM, an interview with DON, revealed that the purpose of the care plan was to show the care that each resident needed so the staff knew how to meet each resident's individual needs. She agreed that the staff did not follow the care plan when they failed to provide oral and nail care for Resident #31.<br><br>Resident #37<br><br>Record review of Resident #37's "Care Plan" revealed, "Problem Onset: Resident has a DX (diagnosis) of Post Traumatic Stress Disorder/Emotional Trauma." The approaches were not individualized and did not address potential triggers/fears related to her history of trauma.<br><br>Record review of the facility "Social Assessment" for Resident #37, dated 5/1/2024 revealed, Resident #37 had not experienced a traumatic event in the past, trauma-related symptoms, nor any impact to her daily routine.<br><br>An interview with Social Services (SS) #1 on | F 656 | 1 time a week for the next 4 weeks, to start on 8/5/24 and end on 9/5/24 and then monthly for the next 3 months and then quarterly.<br><br>The DON will also present her findings of her audits in the Quarterly Quality Assurance (QA) committee meeting until substantial compliance is achieved. If any negative findings occur with the current plan of correction, the QI committee will revise the plan if correction until compliance is obtained.<br><br>An initial Quality Assurance Committee Meeting was conducted 7/24/24 and the flow-up Quality Assurance Committee Meeting will be conducted on September 6, 2024 and monthly if needed to discuss findings from annual survey in reference to Development/Implementing Comprehensive Care Plans. | |

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| F 656 | Continued From page 6<br>7/23/2024 at 10:45 AM, revealed Resident #37 did have inappropriate touching behaviors and would touch residents and staff.<br><br>An interview with LPN #2 on 7/23/2024 at 2:40 PM, confirmed she was aware that Resident #37 had a diagnosis of PTSD, and revealed the resident did not like people to hug her.<br><br>An interview with the Director of Nursing (DON) on 7/23/2024 at 2:53 PM, confirmed a comprehensive resident specific care plan was not developed to include Resident #37's fears and possible triggers for re-traumatization and behavior expressions staff should be aware of. She revealed the care plan was not developed because the trauma informed care assessment was not completed.<br><br>An interview with the Minimum Data Set (MDS) Nurse on 7/23/2024 at 3:45 PM, revealed the purpose of the care plan was to know how to care for the resident. She confirmed the care plan for Resident #37 was not individualized and did not address possible triggers or resident specific approaches for PTSD. | F 656 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and facility policy review the facility failed to provide Activities of Daily Living as evidenced by failure to provide | F 677 | 1.On 7/23/24 the Registered Nurse (RN) Supervisor cleaned Resident #31 nails and provided oral care to his mouth at | 9/6/24 |

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| F 677 | Continued From page 7<br>daily oral care and nail care for one (1) of 16 residents reviewed. (Resident #31)<br><br>Findings Included:<br><br>Record review of the facility policy, "Oral Hygiene" with revision date of 10/17 revealed Purpose: To clean the mouth, teeth, gums ...To remove bacteria and odor... Procedure...1. Offer oral hygiene before breakfast, and at bedtime..."<br><br>Record review of the facility policy, "Nail Care" with review date of 01/24 revealed "Purpose: To promote cleanliness, safety and a neat appearance... Procedure...7. Remove any debris from under the nails with the orangewood stick..."<br><br>On 07/22/24 at 10:00 AM, an observation of Resident #31 revealed he was lying in bed, alert with his mouth open and a yellow substance covering all of his teeth. An observation of his hands revealed a brown substance under the fingernails of his left hand.<br><br>On 07/23/24 at 9:45 AM, an observation with Licensed Practical Nurse (LPN) #1, revealed Resident #31 lying in his bed with a yellow substance covering his teeth and a brown substance under the fingernails of his left hand. LPN #1 confirmed that he had yellow buildup on his teeth and revealed this could cause tooth decay and other problems with his mouth. She revealed that the Certified Nursing Assistants (CNA)s were supposed to do mouth care every day and usually did this during their morning rounds while they were doing their baths. LPN #1 revealed they used mouth swabs to clean Resident #31's teeth because they were afraid of aspiration if they tried to brush his teeth. She | F 677 | 10:15 a.m. Residents nail and oral care was audited by the Director of Nurses (DON) at 10:45 a.m. and there were no negative findings.<br><br>2. All 55 currently residing in the 60 bed facility who receive medical care have the potential to be negatively affected by this deficient practice.<br><br>3. An in-service was conducted by the Staff Development Licensed Practical Nurse (LPN) on the facility policy and procedure for "Oral Hygiene" and a separate in-service was conducted by the Staff Development LPN on the facility policy and procedure on "Nail Care" on 7/23/24 at 10:30 a.m. The RN Supervisor checked all residents nail care and oral care in the building and there were no negative findings on 7/23/24 at 2:00 p.m.<br><br>4. RN Supervisor will audit residents daily for compliance with nail care and oral care policy daily for the next 4 weeks, starting 8/5/24 and ending 9/5/24 and then 2 times a week for 4 weeks if no other problems are identified.<br><br>The RN supervisor will also present findings to the Quarterly Assessment and Improvement Committee Meeting meeting on 9/6/24 and then quarterly at each QI meeting until substantial compliance is achieved. If any negative findings occur with current plan of correction, the QI committee will revise the current plan if correction until compliance is obtained. | |

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| F 677 | Continued From page 8<br>agreed that Resident #31's mouth care had not been done. LPN #1 also confirmed the brown substance under the fingernails of Resident #31's left hand and stated, "I will find some clippers and do the nails now." She revealed that they scheduled fingernails to be clipped every Sunday, but nails should be looked at every day and checked for cleanliness. LPN #1 agreed dirty fingernails could cause infection if he scratched himself and the CNAs should have taken care of this.<br><br>On 07/23/24 at 9:50 AM, an interview with Director of Nursing (DON), revealed mouth care was supposed to be completed at least once a day. She revealed the CNAs were responsible for completing mouth care and they used mouth swabs if the residents couldn't tolerate brushing their teeth. The DON confirmed personal hygiene included nail care and mouth care. She revealed that the CNAs were responsible for checking fingernails and this should be done every day. She also revealed that failure to provide nail care and oral care was unacceptable and could cause sores in the mouth, tooth decay and other problems. The DON stated, "This makes me angry."<br><br>Record review of Resident #31's Face Sheet revealed an admission date of 08/08/19 and included diagnoses of Parkinson's Disease, Dysphagia following Cerebral Infarction, and Cognitive Communication Deficit. | F 677 | An initial Quality Assurance committee meeting was conducted on 7/24/24 and a follow up Quality Assurance committee Meeting will be conducted on 9/6/24 and monthly if needed to discuss findings from annual survey in reference to ADL care provided to dependent Residents. | |
| F 699 SS=D | Trauma Informed Care<br>CFR(s): 483.25(m)<br><br>§483.25(m) Trauma-informed care<br>The facility must ensure that residents who are | F 699 | | 9/6/24 |

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| F 699 | Continued From page 9<br>trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to complete a Trauma Informed Care Assessment for a resident with a diagnosis of Post Traumatic Stress Disorder (PTSD) for one (1) of 1 resident reviewed for Trauma Informed Care. Resident #37<br><br>Findings Include:<br><br>Review of the facility policy titled "Social Documentation - Progress Notes" with a revision date of 10/23 revealed under, "Policy: Social Progress Notes should be entered into the resident's Medical Record during the observation period of each MDS (Minimum Data Set) and whenever unusual circumstances occur, or for changes in resident condition or status."<br><br>An observation and interview with Resident #37 on 7/22/2024 at 12:35 PM, revealed she was sitting in a wheelchair in her room. Resident was verbal with few words and stated, "I'm fine."<br><br>Record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/2/2024 revealed, under section I, Resident #37 has a medical diagnosis of PTSD. Also revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicates the resident is cognitively intact. | F 699 | 1. On 7/23/24 at 11:00 a.m. Social Services (SS)#1 completed the social assessment for Resident # 37 that included trauma-informed care practices.<br><br>2. All 55 residents currently residing in the 60 bed facility have the potential to be affected by this deficient practice.<br><br>3. An in-service was completed by the Staff Development Nurse on 7/23/24 at 12:05 p.m. for SS#1 on facility Policy titled "Social Documentation - Progress Notes".<br><br>4. An audit will be conducted by the Minimum Data Set (MDS) nurse for each resident who is in their observation period, or whenever unusual circumstances occur, or for changes in resident condition or status daily to ensure assessment information is updated according to each residents individual needs. This audit will take place for 4 weeks from 8/5/24 until 9/5/24.<br><br>The MDS nurse will present findings of audits in the Quarterly Quality Assessment and Improvement Committee a If any negative findings occur with the current plan of correction, the QI committee will revise the plan of | |

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| (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 699 | Continued From page 10<br><br>An interview with Social Services #1 (SS) on 7/23/2024 at 10:45 AM, explained that social assessments were due quarterly, and Resident #37 was upcoming but had not been completed yet. SS #1 confirmed she was aware that Resident #37 had a history of traumatic events, and revealed she was notified upon starting the social services position. She revealed to her knowledge the resident was diagnosed with PTSD after she was sent for a behavioral health stay and confirmed the facility did not have a social assessment that identified she had a traumatic history.<br><br>Record review of Resident #37's "Psychiatric Evaluation" from the behavior health stay, dated 8/20/2022, revealed "(Traumatic event) as a teen. States has bad dreams about it a lot." Also revealed under, "Plan:.. Add Zoloft (anti-depressant)...daily for questionable PTSD symptoms."<br><br>Record review of the facility "Social Assessment" for Resident #37, dated 5/1/2024 revealed, Resident #37 had not experienced a traumatic event in the past nor experienced any trauma-related symptoms.<br><br>An interview with Licensed Practical Nurse (LPN) #2 on 7/23/2024 at 2:40 PM, revealed she was the nurse caring for Resident #37 today. She confirmed she was aware that the resident had a diagnosis of PTSD and revealed the resident did not like people to hug her.<br><br>An interview with the Director of Nursing (DON) on 7/23/2024 at 2:53 PM, confirmed Resident #37 did not have a trauma informed care assessment | F 699 | correction until compliance is obtained.<br><br>An initial Quality Assurance Committee meeting was conducted on 7/24/24 and a follow up quality Assurance committee meeting will be conducted on 9/6/24 and monthly if needed to discuss findings from annual survey in reference to Trauma informed Care. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255279 | A. BUILDING _____ B. WING _____ | 07/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| F 699 | Continued From page 11<br>completed to address the resident's diagnosis of PTSD and revealed it should have been done to address any symptoms and possible triggers.<br><br>Record review of the "Admission Record" revealed the facility admitted Resident #37 on 6/25/21 with medical diagnoses that included Personal history of traumatic brain injury and Unspecified convulsions. A medical diagnosis of Post-Traumatic Stress Disorder was added to the resident's diagnoses list on 8/26/2022. | F 699 | | |