MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	54NP	A. BUILDING: _____ B. WING _____	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SARDIS COMMUNITY NH	613 EAST LEE STREET SARDIS, MS 38666

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M 000	Initial Comments The State Agency (SA) conducted an Annual Recertification survey at the facility from 06/29/25 through 07/01/25. 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 requirements and cited M610, M735, M1210, and M1570. The census at the time of the survey was 55 and the facility was licensed for 60 beds.	M 000		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Pattern Based on observation, interviews, record review and facility policy review, the facility failed to ensure that assistance with Activities of Daily (ADL) was provided to a resident that required assistance with bathing for one (1) of 26 sampled residents. Resident #257 Findings Include: Review of the facility's policy titled, "Activities of	M 610	On 6/30/202,5 Resident #257 received a shower from the CNA (Certified Nursing Assistant) completing showers for residents on his hall that day. The RN supervisor made rounds with the shower list to ensure all residents were receiving either a bath or a shower according to their personal preference. A bath or shower was given on 6/30/2025 to all other residents according to their personal preference.	8/4/25

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M 610	Continued From page 1 Daily Living" with a revision date of 11/24, revealed under "Policy: Activities of Daily Living will be documented on a daily basis by the CNA (Certified Nursing Assistant) to reflect actual care rendered to the resident. The ADL shall become a permanent part of the residents' chart... 2. ADLS shall include, but are not limited to ...bathing ..." On 6/29/25 at 4:58 PM, an observation of Resident #257 revealed a foul odor. An interview with Resident #257, revealed that he had not received a bath or shower since his admission two weeks ago. During an observation and interview on 6/30/25 at 11:00 AM, the resident was observed wearing the same pants as the day before and continued to have a foul odor. Resident #257 stated that he had not gotten a bath or shower this morning. His brother, who is also his roommate, stated that he had not seen Resident #257 get a bath or go to the shower room since his admission. An interview with 6/30/25 at 2:00 PM with CNA #1, revealed that she helps on the hall, and that Resident #257 is scheduled to receive a bath on Mondays, Wednesdays, and Fridays. She stated, "I can't remember when he had a bath or shower." She attempted to locate documentation but was unable to provide any dates. Record review of the Kardex Follow Up Question Report 6/16/25 through 6/30/25 revealed documentation of personal hygiene, but there were no notations of a bath or shower in the record. During an interview on 6/30/25 at 2:15 PM with Licensed Practical Nurse (LPN) #1, she stated, "I don't recall when he received a bath or shower."	M 610	All residents have the potential to be negatively affected by this deficient practice. On 6/30/2025, an in-service was completed by the Staff Development Nurse for all nursing staff on the facilities "Activities of Daily Living Policy". The Director of Nurses (DON) initiated a 100 % audit on 7/1/2025 on the resident Activities of Daily Living (ADL) Tasks to ensure that each residents preference for either a shower or bath was indicted on their ADL tasks and that the CNA's had completed the task. The audit was complete on 7/3/2025. The DON (Director of Nurses) will audit residents Activities of Daily Living (ADL) tasks to ensure that the residents preference for either a shower or a bath are being met and that they are receiving them according to their preference for all newly admitted residents and ten additional residents weekly for four weeks, starting 7/1/2025 and ending 8/1/2025 and then once monthly for the next three months and then once quarterly thereafter until substantial compliance is achieved. The Quality Assurance and Performance Improvement (QAPI) Committee will convene on 8/1/2025 to discuss further recommendations as needed and will meet once a month for three months until substantial compliance is achieved. The QAPI Committee will revise the corrective action plan as needed until substantial compliance is achieved.	

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M 610	Continued From page 2 She also stated, "He has never refused care with me." On 7/01/205, an interview with the Director of Nursing (DON), confirmed that Resident #257 should have received a bath or shower on Mondays, Wednesdays, and Fridays. Record review of Resident #257 "Admission Record" revealed the facility admitted Resident #257 on 6/16/2025 with diagnoses including Parkinson's Disease. Record review of Resident #257 Minimum Data Set (MDS), Section C, with an Assessment Reference Date (ARD) of 6/23/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #257 is cognitively intact.	M 610		
M 735	45.25.1 Medical Records Management Medical Records Management. 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use.	M 735		8/4/25

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M 735	Continued From page 3 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary, including the final diagnosis. 5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records. 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge. 8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years. 9. A resident index, including the resident's full name and birth date, shall be maintained. This Statute is not met as evidenced by: Level II Based on staff interviews, record review, and	M 735	On 6/30/2025, Resident #36 wound orders were performed by Registered Nurse (RN) # 2 and the treatment was documented on	

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M 735	Continued From page 4 facility policy review, the facility failed to document wound treatments for a resident with a Stage 3 pressure ulcer for one (1) of three (3) residents with wounds reviewed. Resident #36 Findings include: Record review of facility policy titled, "Physician Orders" with a revision date of 01/25, revealed, "It is the policy of this facility that all physician's orders will be implemented timely and carried out in a professional manner. ... Licensed nurses are responsible for following physician orders." Record review of Electronic Treatment Administration Record (ETAR) for April 2025 and May 2025 revealed an order with a start date of 4/15/25 and a discontinue date (D/C) date of 5/9/25 to "Clean pressure ulcer stage 2 to sacral with wound cleanser. Pat day. Apply mupirocin and collagen to wound and cover with foam dressing daily until healed." Treatments for 4/19/25, 4/21/25, 4/27/25, 5/2/25, and 5/9/25 were not documented as administered. Record review of ETAR for May 2025 revealed an order with a start date of 5/10/25 and a D/C date of 5/23/25 to "Cleanse with wound cleanser and apply Dakins wet to dry x 2 weeks and then rephotograph one time a day for treatment." Treatments for 5/18/25, 5/21/25, and 5/22/25 were not documented as administered. Record review of ETAR for May 2025 and June 2025 revealed an order with a start date of 5/24/25 and a D/C date of 6/5/25 to "Clean wound to sacral area with wound cleanser. Pat dry. Apply mupirocin and alginate to wound and cover with bordered dressing every day until healed." Treatments for 5/25/25, 5/29/25, 6/2/25, and	M 735	the Treatment Administration Register (TAR). The Director of Nurses (DON) completed a 100% audit for all residents receiving wound treatments between April 1, 2025 and July 1, 2025 to ensure that each individual resident was documented to have received the wound care according to their physicians orders. All physicians orders for wound treatments in the facility were also audited by the DON to ensure that they were correct and being carried over to the TAR for nurse implementation and documentation on 6/30/2025. Any and All residents have the potential to be negatively affected by this deficient practice. An in-service was conducted by the DON for all RN's and LPN's that work in the facility on 6/30/2025 on the facility policy "Physician Orders". Additionally, the DON conducted an in-service on the facility "Nursing Documentation" policy with all nurses on 6/30/2025. Starting on 7/1/2025 the DON audited the TAR to ensure that the RN's and LPN's were documenting on the TAR and that they have completed the wound treatments according to the physicians orders. The DON also audited that the wound treatments were completed with each resident on the TAR and that the treatment had been completed according to the physicians orders. Beginning 7/1/2025 and ending 8/1/2025, the DON will monitor the TAR for completed documentation and wound	

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M 735	Continued From page 5 6/4/25 were not documented as administered. Record review of ETAR for June 2025 revealed an order with a start date of 6/6/25 and a D/C date of 6/10/25 to "Clean wound to sacral area with normal saline, pat dry, apply mupirocin, hydrofera blue, calcium alginate and cover with foam dressing daily and PRN (as needed) when soiled until healed." Treatment for 6/8/25 was not documented as administered. Record review of ETAR for June 2025 revealed an order with a start date of 6/11/25 to "Clean Stage 3 pressure injury to sacral area with normal saline, pat dry, apply mupirocin, hydrofera blue, calcium alginate and cover with foam dressing daily and PRN when soiled until healed." Treatments for 6/21/25 and 6/22/25 were not documented as administered. On 06/30/25 at 11:00 AM, wound treatment observation and interview with Registered Nurse (RN) #2 revealed wound management services visits weekly on Wednesdays. She revealed she started at the facility in April 2025 and Resident #36 had a little bit of breakdown and we were treating it then and now it is looking much better with pink granulation. This observation confirmed the wound had pink granulation. During an interview and record review on 6/30/25 at 12:20 PM, the Director of Nurses (DON) confirmed that after reviewing the ETAR for Resident #36's wound treatment, there were fifteen days with missing documentation for the months of April, May, and June. She revealed that it is our expectation that all treatments are documented in the system, and if another nurse goes in to render treatment and finds a bandage with an old date, they will report it to me. She	M 735	treatments by the nursing staff per the physicians orders. This monitor will continue once weekly for four weeks, and then once monthly for three months and then once quarterly, thereafter until substantial compliance is obtained. The Quality Assurance and Performance Improvement (QAPI) committee will convene on 8/1/2025 to discuss further recommendations as needed and will meet once a month for three months until substantial compliance is obtained. The QAPI Committee will revise the corrective action plan as needed until substantial compliance is achieved.	

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M 735	Continued From page 6 revealed I just can't imagine that my nurses wouldn't do a treatment, I think they have gotten busy and failed to document in the ETAR. She revealed that documenting care is part of the continuity of care, and treatments should be done and documented accurately. During an interview on 6/30/25 at 4:35 PM, Licensed Practical Nurse (LPN) #3 revealed she used to be the wound treatment nurse and still helps with treatments at times. She revealed she has not seen where treatments haven't been done. She revealed that if she had noticed a wound bandage with an old date then she would have reported that to the DON. She revealed that she thinks the nurses failed to document the care that they did. She revealed that she has honestly forgot to document treatment a few times herself. In an interview on 6/30/25 at 4:59 PM, Registered Nurse (RN) #2 revealed that she is the treatment nurse and works Monday-Friday. She revealed she is new as the treatment nurse and tries to ensure she documents in the system when she provides care. She revealed that she was not sure about the weekend nurses' documentation. Record review of Resident #36's "Admission Record" revealed the facility admitted the resident on 5/8/24 with diagnoses which included Chronic Kidney Disease, Stage 4, and Dementia. Record review of Minimum Data Set (MDS) Section C with Assessment Reference Date (ARD) of 5/27/25 revealed that Resident #36 was rarely or never understood.	M 735		
M1210	45.40.7 Walls and Ceilings	M1210		8/4/25

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M1210	Continued From page 7 Walls and Ceilings. All walls and ceilings shall be of sound construction with an acceptable surface and shall be maintained in good repair. Generally the walls and ceilings should be painted a light color. This Statute is not met as evidenced by: Level II Based on observation, staff and resident interviews, record review and facility policy review, the facility failed to provide a homelike environment for one (1) of 55 residents residing in the facility. Resident #40. Findings include: Review of the facility policy titled, "Resident Environment," dated 9/15 with no revision date revealed, "It is the policy of this facility to provide a safe, clean, comfortable and homelike environment ..." During an observation on 6/29/25 at 4:00 PM, it was noted that Resident #40's room had an approximate two feet by four feet area of paint missing from the wall across from the bathroom door. The resident expressed concern, stating, "It's been that way since I moved in here. Sometimes my family comes to visit me. I wouldn't have my home looking like that." During an observation and interview with the Maintenance Director on 6/30/25 at 12:52 PM confirmed that he was aware of the missing paint and stated, "I just haven't got around to it." He further remarked, "I wouldn't want my house to look like that, and this is their home and that they are supposed to be provided with a homelike environment."	M1210	On 6/30/2025. the Maintenance Director painted the unpainted area on the wall of Resident #40's room. Additionally, the Maintenance Director made rounds to every residents room and painted all areas that were found to have not been painted. All 55 currently residing in the 60 bed facility have the potential to be negatively affected by this deficient practice. An in-service was conducted on 6/30/2025 at 2:00 p.m. for the facility Maintenance Director by the facility Administrator to complete all maintenance work orders timely and to round weekly correcting any issues that he finds that would prevent our residents from having a homelike, safe, clean, comfortable environment according to our facility "Resident Environment Policy". Additionally, all staff was in-serviced on 6/30/2025 at 2:00 p.m. to report any issues that could prevent any resident from having a homelike, safe, clean, comfortable environment according to our facility "Resident Environment Policy". Upon hire, annually and as needed all staff that are trained to report any issues that they see in the facility to the maintenance director and/or Administrator. On 6/30/2025 a one-hundred percent audit	

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M1210	Continued From page 8 During an interview with the Administrator on 6/30/25 at 12:54 PM, she acknowledged the facility's responsibility to maintain a homelike environment and admitted to failing to notice the issue during her rounds. Record review of the "Admission Record" revealed that the facility admitted Resident #40 on 5/6/22. Record review of the quarterly MDS (Minimum Data Set) with an Assessment Reference Date (ARD) of 5/14/25 under Section C, revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating that the resident had moderate cognitive impairment.	M1210	was conducted by the Administrator for all 55 residents residing in the facility to ensure that they were satisfied with their environment and that they felt safe, at home, that it was clean and comfortable to them. The audit was completed on 6/30/2025 with no other negative findings. Beginning 7/01/2025, the Administrator will conduct Resident Environment Rounds checking on each resident two times a week for four weeks to ensure that they feel safe, at home, comfortable and in a clean environment weekly for four weeks and then once monthly for three months and then once quarterly thereafter until substantial compliance is achieved. The Quality Assurance and Performance Improvement (QAPI) will convene on 8/1/2025 to discuss further recommendations as needed and will meet once a month for three months until substantial compliance is obtained.	
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	M1570		8/4/25

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M1570	Continued From page 9 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 Statute is not met as evidenced by: Level II Based on observations, staff interviews, record reviews, and facility policy review, the facility failed to prevent the potential spread of infection by not ensuring staff performed proper hand hygiene during three (3) of nine (9) direct care observations. Specifically, staff failed to perform hand hygiene before and after medication administration and during wound care procedures, which poses a risk of cross-contamination and infection transmission. Findings include: Review of the facility policy titled, "Hand Hygiene" with a revised date of 1/24 revealed the following: "Purpose: To cleanse hands to prevent transmission of infection or other conditions." 2. ..."Hand hygiene should be performed between all contact with residents or when entering and exiting a resident's room." Review of the facility policy titled, "Dressing Change Policy and Procedure" with a revised date of 3/14, revealed the following: ...9. Put on	M1570	On 6/30/2025, Licensed Practical Nurse (LPN) #1 found a bottle of hand sanitizer and sanitized her hands between each resident when it was brought to her attention that she needed to sanitize her hands between giving medicines to each individual resident. Additionally, Registered Nurse (RN)#2 changed her gloves between taking the soiled dressing off and performing the clean treatment for each individual wound after it was brought to her attention. The Director of Nurses (DON) monitored the medication pass for LPN #2 for the duration of her shift on 6/30/25 ensuring that she sanitized her hands between each individual resident while giving medications. The Staff Development Nurse (SD) monitored RN #2 during the remainder of the treatments that she performed during her shift on 6/30/2025. All residents have the potential to be negatively affected by this deficient practice.	

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M1570	Continued From page 10 disposable gloves. 11. ...Remove dressing. Pull gloves over dressing and discard them into appropriate plastic waste bag. 12. Perform hand hygiene. Put on disposable gloves. 13. Irrigate/cleanse the area as ordered. 16. Perform hand hygiene. Apply disposable gloves. 18. Dress the area with the prescribed dressing. An observation on 6/30/25 at 7:35 AM revealed that Licensed Practical Nurse (LPN) #1 failed to wash her hands prior to setting up the medications from the medication cart, entered resident room number 147A and administered the medications without washing her hands. LPN #1 exited the room and failed to wash her hands or use hand sanitizer before setting up the medication for resident room number 148B. LPN #1 entered resident room #148B and administered medications without washing her hands. An interview on 6/30/25 at 7:50 AM, LPN #1 confirmed that she didn't wash or sanitize her hands before setting up or administering both residents' medications. She confirmed that she should have practiced hand hygiene to prevent cross-contamination and prevent infections. LPN #1 stated, "I guess I need to go up front and get myself a bottle of hand sanitizer for my cart." On 6/30/25 at 11:00 AM, an observation of wound care provided by Registered Nurse (RN) #2 revealed that RN #2 gathered her supplies, entered Resident #36's room, washed her hands, and donned gloves. RN #2 removed the soiled bandages from the sacral wound, proceeded with the wound treatment and cleaned the sacral wound with normal saline. She then patted dry with a 4x4 gauze, applied mupirocin, covered with hydrofera blue and calcium alginate, and covered	M1570	An in-service was conducted on 6/30/2025, by the Staff Development Nurse on the facilities "Hand Hygiene Policy" for all nurses. On 6/30/2025, the SD nurse audited the nurses on the procedure for sanitizing your hands between giving medications to each individual resident for all nurses in the facility. This audit was completed with all nurses on 7/7/2025. Additionally, the Staff Development Nurse conducted an in-service on 6/30/2025 with all nurses on the facility policy labeled "Dressing Change Policy and Procedure". An audit was completed by the SD nurse for all nurses performing wound treatments in the facility on 6/30/2025. The audit was completed with all facility nurses by 7/7/2025. The Director of Nurses (DON) will audit two medication passes a week for compliance with facility Hand Hygiene Policy for four weeks starting 7/1/2025 and ending 8/1/2025 and then monthly for the next three months and then once quarterly thereafter until substantial compliance is achieved. Additionally the DON will monitor two wound treatments a week for compliance with facility Dressing Change Policy and Procedure four weeks starting 7/1/2025 and ending 8/1/2025 and then once monthly for the next three months then once quarterly thereafter until substantial compliance is achieved. Both audits Hand Hygiene Policy and	

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	54NP	A. BUILDING: _____ B. WING _____	07/01/2025

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SARDIS COMMUNITY NH	613 EAST LEE STREET SARDIS, MS 38666

(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) COMPLETE DATE
M1570	Continued From page 11 the sacral wound with a clean foam dressing. This observation revealed RN #2 did not change gloves or perform hand hygiene between the dirty and clean steps of the wound care procedure. On 6/30/25 at 11:15 AM, RN #2 confirmed that she removed Resident #36's dirty wound dressings, cleaned her wound, and then administered her wound treatment, which included a clean dressing without changing her soiled gloves, washing her hands, and applying clean gloves in between the dirty and clean wound treatment process. She revealed this could contaminate the wound and prevent healing. During an interview on 6/30/25 at 11:30 AM, the Director of Nurses (DON) revealed we have done multiple in-services regarding hand washing. Our expectation is that while administering medications, proper hand hygiene is utilized, which is a vital part of ensuring that we possibly prevent the spread of infections. During a subsequent interview on 6/30/25 at 12:10 PM, the DON stated, "It is basic 101 nursing that when doing wound care treatment, you change out your gloves between removing your dirty dressings and cleaning and applying clean bandages. She revealed that not doing proper hand hygiene can aid in the possible spread of a wound infection, and there is no excuse for it. Record review of Resident #36's "Admission Record" revealed the facility admitted the resident on 5/8/24 with diagnoses including Chronic Kidney Disease, Stage 4, and Dementia.	M1570	Dressing Change Policy and Procedure will be reviewed at the Quarterly Quality Assurance and Performance Improvement (QAPI) meeting on 8/1/2025 and then once quarterly at each QAPI meeting until substantial compliance is achieved. If any negative findings occur with the current plan of correction, the QAPI committee will revise the plan of correction until compliance is obtained.	