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 _____	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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) COMPLETION DATE
F 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 Medicare and Medicaid requirements for participation and cited F584, F641, F656, F677, F757, F842, and F880. The census at the time of the survey was 55 and the facility was licensed for 60 beds.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. 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. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		8/4/25

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

Electronically Signed | 07/10/2025

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F 584	Continued From page 1 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: 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."	F 584	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".	

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F 584	Continued From page 2 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." 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.	F 584	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 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.	

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F 641	Continued From page 3	F 641		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record reviews, and facility policy review, the facility failed to accurately code an Admission Minimum Data Set (MDS) assessment for one (1) of 18 resident MDS assessments reviewed. Resident #52	F 641	On 6/30/2025, for Resident # 52 the (Minimum Data Set) MDS Nurse updated the assessment to indicate that the bed rails were being used as "assistive device" and not as a restraint. The MDS Nurse audited 100 % of all resident assistive	8/4/25

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F 641	Continued From page 4 Findings include: Review of facility policy titled, "Resident Assessment," last revised on 9/19, revealed, "...The completed assessment guide the staff in identifying key information about the resident and serves as a basis for identifying resident specific issues and objectives in order to develop a care plan...healthcare professional that completes a portion of the assessment must sign and certify the accuracy of the portion of the assessment that they have completed..." Record review of Resident #52's admission MDS, section P, with an Assessment Reference Date (ARD) of 4/29/25, revealed that the bed rails were coded as a restraint. Record review of Resident #52's Care Plan titled, "Resident's Current Safety Devices and Special Equipment" dated 4/22/25 revealed, "...Side Rails x (times) two (2)...for bed mobility..." An observation of Resident #52's bed on 6/29/25 at 5:04 PM revealed that half side rails were attached. During an interview on 6/30/25 at 9:55 AM with the MDS Coordinator, she acknowledged that Resident #52's bedrails were incorrectly coded, stating the bed rails were used for positioning rather than as a restraint. During an interview with the Director of Nursing (DON) on 7/01/25 at 12:10 PM, she expressed her expectation that MDS assessments accurately reflect the resident's condition and concurred that the bed rails should not have been	F 641	device assessments on 6/30/2025 to ensure that all residents were assessed correctly for assistive devices. Resident #52 bed was changed to a bed with shorter side rails that she could use as an assistive device. All resident have the potential to be negatively affected by this deficient practice. On 06/30/2025, an in-service was conducted by the Director of Nurses (DON) for the MDS nurse on the facility policy titled "Resident Assessment". On 6/30/2025, 100% audit was initiated by the DON to ensure that each resident was assessed for the correct assistive device and that it was entered correctly in each individual residents assessment by the MDS nurse. Additionally, the DON monitored each resident that was assessed to have an assistive device and made sure with each individual resident that had an assistive device was serving its purpose with the resident and that they did not feel restrained. Starting 7/2/2025, the DON will monitor each resident assessment performed by the MDS nurse for accuracy with the residents preference for the assistive device, two times a week for the next four weeks and then once monthly for the next three months and then once quarterly thereafter until substantial compliance is achieved. The Quality Assurance and Performance	

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F 641	Continued From page 5 coded as restraints, emphasizing that they were intended to assist with positioning. She firmly stated, "We do not have restraints in this building." Record review of the "Admission Record" revealed that the facility admitted Resident #52 on 4/22/25 with medical diagnoses that included Traumatic Hemorrhage of Left Cerebrum with Loss of Consciousness Status Unknown. Record review of the admission MDS with an ARD of 4/29/25 under Section C, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating that the resident had severe cognitive impairment.	F 641	Improvement (QAPI) will convene on 8/1/2025 to discuss further recommendations and monitor 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.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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 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	F 656		8/4/25

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F 656	Continued From page 6 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 care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, record reviews and facility policy review, the facility failed to develop a comprehensive care plan for a resident taking an anticoagulant (Resident #32) and failed to implement an Activities of Daily Living (ADL) care plan (Resident #257) for two (2) of 26 resident's care plans reviewed. The scope for F656 was increased to "E" to indicate a pattern of noncompliance due to a prior citation during the last recertification survey 7/23/24.	F 656	On 6/30/2025, the Minimum Data Set (MDS) Nurse completed a comprehensive care plan for resident # 32 to include anticoagulant therapy signs and symptoms monitoring. The Director of Nurses (DON) audited the care plans of 100% of residents receiving anticoagulants on 6/30/2025 to ensure that each individual resident had a comprehensive care plan to include monitoring for adverse signs and symptoms and that the care plan for each	

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F 656	Continued From page 7 Findings include: Review of the facility policy titled, "Care Plan Process" with review date 12/24, revealed, " ...the facility shall develop and implement ...care plan ...for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care ..." Resident #32 Record review of Resident #32's "Physician's Orders" revealed an order with a start date of 4/7/25 for Apixaban Oral Tablet 5 milligrams (mg); Give 1 tablet by mouth two times a day related to Acute Embolism and Thrombosis of Unspecified Femoral Vein. Record review of Resident #32's care plans revealed that a comprehensive care plan had not been developed for anticoagulant therapy. During an interview on 6/30/25 at 11:00 AM with the Minimum Data Set (MDS) Coordinator, she confirmed that a comprehensive care plan addressing the risk for bleeding associated with anticoagulant therapy was absent. She emphasized the critical nature of this oversight, stating that a care plan should have been initiated at the same time the anticoagulant order was entered to ensure proper monitoring. The MDS Coordinator expressed serious concerns, noting that the resident "could die" if active bleeding occurred and went unnoticed due to the lack of monitoring protocols. During an interview with the Director of Nursing	F 656	resident who received a physician's order for an anticoagulant medication was being monitored correctly by the nurses for adverse signs and symptoms. Resident #257 received a shower from the CNA (Certified Nursing Assistant) completing showers for residents on his hall that day 6/30/2025 as indicated on his Activities of Daily Living (ADL) care plan. The RN supervisor made rounds with the shower/bath list to ensure all residents were receiving either a bath or a shower according to their care plan. A bath or shower was given on 6/30/2025 to all other residents according to their care plan. All residents have the potential to be negatively affected by this deficient practice. An in-service was conducted by the DON for the MDS nurse on the facility policy, "Care Plan Process" with the MDS nurse on 6/30/2025. The nursing staff was trained by the DON on how to monitor for signs and symptoms of anticoagulant therapy, document the findings, and notify the Medical Director or Nurse Practitioner if there are any negative findings starting on 6/30/25. 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) completed a	

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F 656	Continued From page 8 (DON) on 7/01/25 at 12:04 PM, she reiterated her expectation that a comprehensive care plan must be developed whenever an anticoagulant is prescribed for a resident. She highlighted the potential consequences of failing to implement such a plan, indicating that a resident could experience a bleed that might go undetected, potentially leading to hospitalization or worse outcomes. Record review of the "Admission Record" revealed that the facility admitted Resident #32 on 3/31/25 with medical diagnoses that included Acute Embolism and Thrombosis of Unspecified Femoral Vein. Record review of the quarterly MDS with an Assessment Reference Date (ARD) of 4/16/25 under Section C revealed, a Brief Interview for Mental Status (BIMS) score of 15, indicating that the resident was cognitively intact. Resident #257 An observation and interview with Resident #257 on 6/29/25 at 4:58 PM, revealed that Resident #257 had a foul odor and stated he had not had a bath or shower since his admission. Record review of the Care Plan Report for Resident #257 revealed: "The resident needs assistance with ADLs (Activities of Daily Living) Date initiated 6/27/25 ...Interventions: ... The resident needs partial/moderate assist to transfer with bathing/showering ..." During an interview with the MDS Coordinator, on 6/30/25 at 2:45 PM, she stated, "The purpose of a care plan is to make sure that staff addresses	F 656	100 % audit on 6/30/2025 on the resident (ADL) Tasks to ensure that each residents care plan for ADL was being carried out according to their care plan and was indicted on their ADL tasks and that the CNA's had completed the task. The DON will audit residents care plans that receive anticoagulant medication to ensure that monitoring for adverse signs and symptoms is included on the comprehensive care plan. This monitor will begin 7/1/2025 and end 8/1/2025 monitoring once weekly for four weeks, then once monthly for three months then once quarterly thereafter until substantial compliance is obtained. The Quality Assurance and Performance Improvement (QAPI) Committee will convene on 8/1/2025 to further discuss 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 obtained. The DON will also monitor residents Activities of Daily Living (ADL) tasks to ensure that the residents ADL care plan 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	

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F 656	Continued From page 9 and provides the care for each resident for their specific care needs." On 7/01/25 at 10:22 AM, the DON stated, "The purpose of a care plan is to provide person-centered care." Record review of Resident #257's "Admission Record" revealed the facility admitted the resident on 6/16/25 with medical diagnoses that included Parkinson's Disease with Dyskinesia, with fluctuations. Record review of Resident #257's MDS with an ARD of 6/23/25 under Section C, revealed a BIMS score of 15, indicating that Resident #257 was cognitively intact.	F 656	Improvement (QAPI) Committee will convene on 8/1/2025 to further discuss 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 obtained.	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §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; This REQUIREMENT is not met as evidenced by: 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 Daily Living" with a revision date of 11/24, revealed under "Policy: Activities of Daily Living	F 677	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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F 677	Continued From page 10 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." She also stated, "He has never refused care with	F 677	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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F 677	Continued From page 11 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.	F 677		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 757		8/4/25

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F 757	Continued From page 12 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record reviews, and facility policy review, the facility failed to monitor the adverse effects of an anticoagulant medication for one (1) of five (5) residents reviewed for unnecessary medications. Resident #32. Findings include: Review of facility policy titled, "Drug Administration and Documentation" with last review date 3/25, revealed, " ...Residents shall be observed for adverse effects such as side effects, interactions, and allergic reactions. The physician shall be notified of any adverse effects that occur ..." Record review of Resident #32's "Physician's Orders" revealed an order with a start date of 4/7/25 for Apixaban Oral Tablet 5 milligrams (mg); Give 1 tablet by mouth two times a day related to Acute Embolism and Thrombosis of Unspecified Femoral Vein. Record review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for Resident #32 for June 2025, it was noted that there was no monitoring protocol in place for the side effects associated with an anticoagulant therapy. During an interview with Licensed Practical Nurse (LPN) #2 on 6/30/25 at 10:12 AM, she revealed	F 757	On 6/30/2025, the Minimum Data Set (MDS) nurse added monitor for signs and symptoms adverse side effects to Resident #32 tasks, which is part of the Medication Administration Record (MAR) since Resident #32 was receiving an anticoagulant medication per physician orders. Resident #32 was assessed by the Director of Nurses (DON) for any adverse signs and symptoms of the anticoagulant medication received on 6/30/2025. Additionally, all residents receiving anticoagulants medications were audited by the DON on 6/30/2025 to ensure that they were being monitored for any adverse signs and symptoms of anticoagulant use and that the findings were being documented on the MAR correctly. All residents have the potential to be negatively affected by this deficient practice. On 6/30/2025, an in-service was conducted by the DON for all nursing staff on the facility policy, "Drug Administration and Documentation". The nursing staff was trained by the DON on how to monitor for adverse signs and symptoms of anticoagulant therapy, document the findings, and notify the Medical Director or Nurse Practitioner if there are any	

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F 757	Continued From page 13 there were no specific orders in place for monitoring the risk for bleeding related to the anticoagulant medication. The LPN emphasized the need for monitoring to detect active bleeding and/or excessive bruising, highlighting the potential for severe complications, such as hospitalization due to bleeding or low hemoglobin (Hgb) and hematocrit (Hct) levels. During an interview on 6/30/25 at 11:00 AM with the Minimum Data Set (MDS) Coordinator, she confirmed that monitoring for the risk of bleeding associated with anticoagulant therapy was absent. She stressed the importance of implementing monitoring tasks concurrently with the initiation of the anticoagulant order to ensure effective oversight. The MDS Coordinator expressed serious concerns, stating that without proper monitoring, the resident "could die" if active bleeding occurred and went unnoticed due to the lack of established protocols. The Director of Nursing (DON) during an interview on 7/01/25 at 12:04 PM, revealed that monitoring for bleeding should commence whenever an anticoagulant is prescribed for a resident. She underscored the potential consequences of failing to implement such a monitoring plan, indicating that undetected bleeding could lead to significant health risks and possible hospitalization. Record review of the "Admission Record" revealed the facility admitted Resident #32 on 3/31/25 with medical diagnoses that included Acute Embolism and Thrombosis of Unspecified Femoral Vein. Record review of the quarterly MDS with an	F 757	negative findings on 6/30/25. The DON will monitor all residents who receive anticoagulants in the facility for correct documentation and for the nurse monitoring for adverse signs and symptoms side effects for each resident for the next four weeks, to start 7/1/2025 and end 8/1/2025. This monitor will continue once monthly for 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 achieved. The QAPI Committee will revise the corrective action plan as needed until substantial compliance is achieved.	

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F 757	Continued From page 14 Assessment Reference Date (ARD) of 4/16/25 under Section C, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating that the resident was cognitively intact.	F 757		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse,	F 842		8/4/25

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F 842	Continued From page 15 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and 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	F 842	On 6/30/2025, Resident #36 wound orders were performed by Registered Nurse (RN) # 2 and the treatment was documented on the Treatment Administration Register (TAR). The	

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F 842	Continued From page 16 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 6/4/25 were not documented as administered. Record review of ETAR for June 2025 revealed	F 842	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 treatments by the nursing staff per the	

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F 842	Continued From page 17 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 revealed I just can't imagine that my nurses wouldn't do a treatment, I think they have gotten	F 842	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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F 842	Continued From page 18 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.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		8/4/25

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F 880	Continued From page 19 The facility must establish and maintain 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880		

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F 880	Continued From page 20 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: 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:	F 880	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	

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F 880	Continued From page 21 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 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	F 880	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. 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	

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 _____	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 22 #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 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	F 880	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 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.	

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F 880	Continued From page 23 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.	F 880		