Mississippi State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>**12/23/2025** |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **SARDIS COMMUNITY NH** | **613 EAST LEE STREET PO BOX 330, SARDIS, Mississippi, 38666** |

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| M0000 | Initial Comments<br><br>The State Agency (SA) conducted a Complaint Investigation (CI) MS #2620733 regarding resident abuse at the facility on 12/23/25. During the survey, the SA determined that the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M500.<br><br>The census at the time of the complaint investigation was 56 and the facility held a license for 60 beds. | M0000 | | |
| M0500 | 45.17.2 Residents' Rights<br><br>Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility:<br><br>1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents;<br><br>2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;<br><br>3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be | M0500 | | |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| M0500 | Continued from page 1<br>limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;<br><br>4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;<br><br>5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;<br><br>6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;<br><br>7. is free from mental and physical abuse;<br><br>8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the | M0500 | | |

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| M0500 | Continued from page 2<br>emergency application of the restraint;<br><br>9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;<br><br>10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;<br><br>11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;<br><br>12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and | M0500 | | |

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| M0500 | Continued from page 3<br><br>16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Level III<br><br>Based on resident and staff interviews, record review, and facility policy review, the facility failed to ensure a resident's right to be free from abuse for one (1) of five (5) residents reviewed (Resident #1), when staff engaged in abusive conduct by pulling the resident from his seated position onto the floor, verbally berating him, and spraying him with an aerosol substance. This failure resulted in actual psychosocial harm, including fear, distress, and compromised dignity.<br><br>Findings Include:<br><br>Review of the facility policy titled “Incident Investigation & Reporting,” revised 5/24, revealed, “...1. Each resident in this facility has the right to be free from any type of abuse including verbal, sexual, mental, physical abuse, neglect, exploitation, misappropriation of resident property...”<br><br>An interview with the Administrator (ADM) on 12/23/25 at 8:58 AM revealed Resident #1 no longer resided at the facility and had been discharged home. She explained that the alleged perpetrator, Nurse Aide (NA) #1, no longer worked at the facility. The ADM stated that on the day of the incident involving Resident #1 and NA #1, the aide left the resident’s room, went outside to her car, refused to talk, and never returned to work. She revealed NA #1 contacted the facility approximately two (2) weeks later, denied intentions to harm the resident, and requested her job back; however, the facility decided to terminate her employment since so much time had passed.<br><br>An interview with the Staff Development Nurse on 12/23/25 at 9:19 AM revealed she was responsible for training nurse aide classes. She stated Nurse Aide (NA) #1 completed the two-week nurse aide training program in August and subsequently trained with a Certified Nurse Aide (CNA) on different shifts. The Staff Development Nurse revealed NA #1 completed all required hours and had 120 days to pass the certification exam, which she had not completed prior to the incident | M0500 | | |

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| M0500 | Continued from page 4<br>involving Resident #1 on 9/17/25.<br><br>Record review of the “Incident Description” dated 9/17/25 revealed, “Summoned to room per CNA and housekeeper. Upon entering room with charge nurse present, resident sitting on floor in front of wheelchair and Nurse Aide #1 sitting in chair in resident’s room. Resident was alert and appeared frightened after altercation with employee. Assisted resident from floor to wheelchair per charge nurse, CNA, and this nurse…. Asked resident what happened resident states, ‘The CNA pulled the pillow from under me pulling me on the floor.’” The record further revealed under “Resident Description: The CNA (Nurse Aide #1) came in my room and stated, ‘I am tired’ and I told her that she can sit in the chair over there and take a break. The CNA sat in the chair for a few minutes, then she got up, walked over to me and stated, ‘I’m tired of y’all playing me.’ Then she pulled the pillow from under me, pulling me on the floor, and sprayed me with that disinfectant spray. I started hollering for help…”<br><br>A telephone interview with Resident #1 on 12/23/25 at 10:50 AM revealed he recalled the incident with Nurse Aide #1 and stated she had come into his room several times that morning but was not supposed to be caring for him that day. He stated he was sitting in his wheelchair and she came into his room and said she was tired, so he told her to sit down in the chair and rest. He stated, “I don’t know if she went crazy or what, but she got up and started taking off my socks and shoes and then pulled a pillow out from under me that I was sitting on and I hit the floor.” He revealed that while he was on the floor, she began hollering at him to “get up, you know you can get up.” He explained he believed she lost control because she picked up an aerosol spray can he believed to be disinfectant and began spraying him over his lower body. He stated he screamed for help, and the housekeeper came to the door, observed him on the floor, and got help. Resident #1 stated that after he was returned to his wheelchair, NA #1 continued spraying his legs with the aerosol spray and began throwing his clothes and items from the bedside table into the garbage can. He explained that he was shaken up by the incident and taken by surprise and it scared him the way she was acting, and he started yelling for help.<br><br>An interview with Housekeeping #1 on 12/23/25 at 11:06 AM revealed that on the day of the incident involving Resident #1, Nurse Aide #1 appeared quiet and was acting unusual. She stated she was cleaning across the hall from Resident #1’s room when she heard him | M0500 | | |

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| M0500 | Continued from page 5<br>hollering and screaming for help. She stated she immediately went to the room and observed NA #1 placing the resident on the floor with her hands. Housekeeping #1 stated the aide was hollering at the resident saying, “You can get up,” while the resident continued screaming for help. She stated she went to the nurse’s desk to get help.<br><br>Record review of the witness statement dated 9/17/25 written by Housekeeping #1 revealed, “I was cleaning 106 (room) when I heard Resident #1 screaming, ‘Stop what you are doing, I’m going to slide on the floor.’ I walked out of 106 to check on him and he was coming out of his chair to the floor and the girl (Nurse Aide #1) was laughing and hollering back at him.”<br><br>An interview with CNA #1 on 12/23/25 at 11:15 AM revealed she was assigned to care for Resident #1 on the day of the incident. She stated Nurse Aide #1 was assigned to a different hall but repeatedly entered Resident #1’s room that morning. CNA #1 stated she was providing care in another room when she heard Resident #1 screaming “Stop, stop, stop,” followed by calls for help. She stated when she entered the room, Resident #1 was on the floor sitting on the wheelchair foot pedals, and NA #1 was hollering at him stating, “You get up, you get up from there.” CNA #1 stated NA #1 began spraying the resident’s legs with an aerosol spray and then threw the resident’s belongings into the garbage can when nursing staff entered the room. She stated, "He told me he was afraid for his life."<br><br>An interview with Registered Nurse (RN) #1 on 12/23/25 at 11:41 AM revealed she was notified during the morning meeting that something had occurred involving Resident #1. She stated upon entering the resident’s room, she observed Resident #1 on the floor and Nurse Aide #1 sitting in a chair laughing. RN #1 stated the resident reported NA #1 had pulled him onto the floor.<br><br>A telephone interview with Licensed Practical Nurse (LPN) #1 on 12/23/25 at 1:17 PM revealed she was Resident #1’s nurse on the day of the incident. She stated CNA #1 and Housekeeping #1 came to the nurse’s desk stating, “Y’all need to get this girl she is doing some crazy stuff.” She stated she and the supervisor entered Resident #1’s room and observed NA #1 sitting in the resident’s chair laughing while the resident was on the floor. She stated Resident #1 reported NA #1 pulled the pillow from under him causing him to fall to the floor. She further stated NA #1 sprayed the resident’s legs with air freshener and continued spraying despite being told to leave the room, then threw items from the bedside table into the garbage | M0500 | | |

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| M0500 | Continued from page 6<br>can. LPN #1 stated the resident was frightened and he told her the girl went crazy.<br><br>An interview with the Administrator (ADM) on 12/23/25 at 1:38 PM revealed she believed the incident involving Resident #1 and Nurse Aide #1 was accidental. She revealed she did a thorough investigation interviewing the staff and they thought NA #1 was fine and stated there were a lot of conflicting stories. She stated she had interviewed the resident twice and the second time he stated that the aide was spraying disinfectant spray in his room that morning, then started rubbing hand sanitizer on his bedside table and it got on one of his pictures. The ADM stated there were too many conflicting stories from staff, some said that NA #1 was spraying disinfectant in the garbage can. She revealed she went to his room and was unable to find any spray aerosol to confirm this. The ADM stated Resident #1 told her that the aide was not trying to intentionally hurt him. She confirmed she spoke with Housekeeping #1 and CNA #1 and still felt as though she could not substantiate the abuse because she could not prove NA #1 showed intent to abuse the resident. She acknowledged that her decision to not substantiate abuse was not supported by the totality of evidence obtained.<br><br>Record review of the witness statements and the interviews obtained during the investigation revealed that abuse did occur and that the resident felt frightened and scared for his life.<br><br>Record review of the “Admission Record” revealed Resident #1 was admitted on 7/11/25 with diagnoses including urinary tract infection, hypertensive urgency, and hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side.<br><br>Record review of the “Evaluation Scoring Report” revealed a Brief Interview for Mental Status (BIMS) score of 12 on 7/18/25, indicating moderate cognitive impairment. | M0500 | | |