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 _____	12/16/2021

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 re-certification survey at the facility from 12/13/21 to 12/16/21. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid regulations for participation. The SA cited deficiencies at F656 for Develop/Implement Comprehensive Care Plan and F695 for Respiratory Care related to oxygen tubing and signage. The facility was licensed for 60 beds and had a census of 46 at the time of the survey.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		1/27/22

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

Electronically Signed | 01/03/2022

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F 656	Continued From page 1 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. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility policy review, and record review, the facility failed to develop a comprehensive care plan in the required timeframe for oxygen (O2) therapy for one (1) of four (4) residents reviewed for oxygen therapy. Resident #46. Findings include: Review of facility policy titled, "Care Plan Process," latest revision 08/17, revealed, " ... The RAI (Resident Assessment Instrument) will be used to determine guidelines for revisions and completion dates for the Comprehensive Care Plan ..." Record review of the "Care Plan" with a problem onset date of 11/17/21 revealed "Resident receives oxygen therapy" with handwritten	F 656	The Comprehensive Care Plan for Oxygen (02) Therapy for Resident #46 was completed on 12/15/2021, by Nurse Case Manager. The Assessment Nurse responsible for timely completion of Resident # 46 Comprehensive Care Plan was educated and in-serviced on 12/28/2021 by Director Of Nursing (DON). All residents have the potential to be affected by this deficient practice. Residents with physician orders for oxygen had Comprehensive Care Plans for Oxygen (02) Therapy checked for compliance January 3, 2022, by Interdisciplinary Team. The Assessment Nurses and Director of Nurses (DON), will audit 5 resident charts weekly for one	

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F 656	Continued From page 2 documentation listed under approaches revealed "Completed 12/15/21 , Care plan not completed prior to 12/15/21." This documentation was signed by the MDS Nurse. An interview, on 12/14/21 at 03:27 PM, with the Minimum Data Set (MDS) Nurse, revealed the comprehensive/patient-centered care plan for all residents are supposed to be completed in 21 days from admission. The MDS Nurse stated Resident #46's comprehensive/patient-centered care plan, for O2, was not completed. It was due to be completed by 12/8/21. The MDS nurse stated it was not complete because she had not gotten to it yet. Record review of Resident #46's Face Sheet revealed he was admitted on 11/17/21 with diagnoses that included Pleural Effusion, not elsewhere classified. An interview, on 12/14/21 at 03:45 PM, with the Director of Nursing (DON), confirmed a comprehensive/patient-centered care plan had to be present, on all residents, to guide staff on resident care needs. The DON stated that Resident #46's comprehensive/patient-centered care plan for O2 should have been completed already. The DON stated by not having a comprehensive/patient-centered care plan for O2 could cause Resident #46 to receive inadequate care.	F 656	month and then 5 charts each month for 3 months beginning 01/03/2022, to ensure compliance with F-656. DON will audit Oxygen Therapy Care Plans for timely completion within 21 days of admission for all new admissions beginning 1/05/22, until substantial compliance is achieved. Interdisciplinary Team was in-serviced on 12/28/2021 by Facility Quality Improvement Nurse regarding timely completion of Comprehensive Care Plans for Oxygen Therapy. The Administrator or DON will report findings from audits regarding F-656 in Weekly Facility Department Head Meeting beginning 1/10/2022, for 4 weeks and then monthly for 3 months and then quarterly at each Quality Assurance Committee Meeting until substantial compliance is achieved. If problems or concerns are identified with current corrective action plans, the QA committee will revise the plan of correction until compliance is obtained.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who	F 695		1/27/22

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F 695	Continued From page 3 needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, record review, and facility policy review, the facility failed to date the oxygen tubing, date the humidification bottle, place a sign outside the room indicating oxygen usage and provide a storage bag for tubing for two (2) of four (4) residents reviewed for oxygen. Resident #40 and Resident #46. Findings include: Review of facility policy titled, "Oxygen-Administration, Concentrator, Storage, Assemblage", latest revision 10/17, revealed ...13. Post the "NO SMOKING - OXYGEN IN USE," sign on the door of resident's room..." The facility policy did not address labeling of the oxygen tubing/nasal cannulas. Review of facility policy titled, " Infection Control Oxygen Equipment Cleaning," revealed "Use disposable tubing, masks, and cannulas for patients receiving oxygen therapy.This equipment is to be discarded as this procedure dictates.. 5. Pre-filled humidifiers are to be dated and replaced when the water level is insufficient to provide humidification, but not less than once per month ... 7. Tubing should be replaced every 7 days ... 9. Cannulas should be replaced every 7 days. 10. When not in use, store the	F 695	Resident #40 and Resident #46 had oxygen tubing and humidification bottles properly dated on 12/15/2021, by Director of Nursing. Resident #40 and Resident #46 had proper signage placed outside the room indicating oxygen usage on 12/15/2021, by Director Of Nursing. Resident #40 and Resident #46 had a storage bag for oxygen tubing placed in rooms on 12/15/2021, by Licensed Practical Nurse (LPN) #2. All nurses responsible for dating tubing and humidification bottles, placing proper signage for oxygen usage and providing storage bag for oxygen tubing for Resident #40 and Resident # 46 were in-serviced and educated on 12/17/2021, by Director Of Nursing. All residents who have orders for oxygen have the potential to be affected by this deficient practice. Director of Nursing (DON) and Nurse Case Manager (NCM) inspected all resident's rooms who have orders for oxygen on 12/16/21, to ensure that all tubing and humidifier bottles were dated, that all rooms had proper "No Smoking-Oxygen In- Use" signs and that all rooms with oxygen concentrators have storage	

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F 695	Continued From page 4 mask/cannula in a plastic bag clearly labeled with the resident's name and date." Resident #40 An observation on 12/13/2021 at 10:30 AM, revealed Resident #40 was asleep and the oxygen tubing and nasal cannula were on the floor. The oxygen tubing and the humidifier water bottle were undated and there was no bag for storage of tubing. An interview on 12/13/2021 at 4:02 PM, with Resident #40 revealed she kept her oxygen cannula within reach and used when needed to improve her shortness of breath. An interview on 12/15/2021 at 10:30 AM, with Licensed Practical Nurse (LPN) # 2 revealed the resident's oxygen tubing was undated and did not have a storage bag for her tubing when not in use. LPN #2 confirmed a bag was needed to keep the cannula clean. Record review of Resident #40's Physician's Telephone Order, dated 8/5/21, revealed "Resident may use O2 via BNC (by nasal cannula) continuously at 2L/min (liters/minute)." Review of Resident #40's Face Sheet revealed the resident was admitted to the facility on 8/5/2021 with diagnoses that included Congestive Heart Failure, Emphysema, and Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/15/21 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #40 was	F 695	bags for oxygen tubing. DON in-serviced nurses on 12/17/2021, on policy "Oxygen-Administration, Concentrator, Storage, Assemblage and Infection Control Oxygen Equipment Cleaning". Administrator and DON will make rounds weekly beginning 01/03/2022, for one month and then monthly for 3 months to ensure compliance with F-Tag 695. The Administrator or DON will report findings from audits regarding F-695 in Weekly Facility Department Head Meeting beginning 1/10/2022, for 4 weeks and then monthly for 3 months and then quarterly at each Quality Assurance Committee Meeting until substantial compliance is achieved. If problems or concerns are identified with current corrective action plans the QA Committee will revise the Plan of Correction until compliance is obtained.	

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F 695	Continued From page 5	F 695		

cognitively intact.

Resident #46

An observation, on 12/13/21 at 10:01 AM, revealed Resident #46 had no date on the Oxygen (O2) tubing, no O2 storage bag for the tubing, and no O2 in use signage on the door.

An observation, on 12/14/21 at 03:00 PM, revealed Resident #46 had no date on the O2 tubing, no O2 storage bag for the tubing, and no O2 in use signage on the door.

An observation and interview, on 12/15/21 at 09:19 AM, with Director of Nursing (DON), confirmed Resident #46 had no O2 in use signage on the door, the O2 tubing was not dated, and there was no storage bag for the O2 tubing. The DON revealed that by not having a date on the O2 tubing prohibits other staff from knowing when the tubing was last changed and if the tubing is not changed appropriately the humidified O2 has a higher risk for growth of bacteria.

Record review of Resident #46's Physician's Telephone Order, dated 11/17/21, revealed, "O2 at 2 L (liters) continuously."

Record review of Resident #46's Face Sheet revealed he was admitted on 11/17/21 with diagnoses that included Pleural Effusion, not elsewhere classified.