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 _____	02/13/2020

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 from 02/10/2020 to 02/13/2020. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited the regulatory deficiencies at F770 and F880. At the time of the survey, the census was 55, and the facility held a license for 60 beds.	F 000		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to obtain a Urinalysis (U/A) in a timely manner, for one (1) of 16 residents reviewed, Resident #53. Findings include: Review of the facility's "Physician Orders" policy, dated 09/2018, revealed: "It is the policy of this facility that all physician's orders will be implemented timely and carried out in a professional manner." If the order is for lab work, follow-up visits, etc. this information will be	F 770	The Urine Analysis with reflex ordered on 01/20/2020 and collected on 01/28/2020 by a Licensed Practical Nurse for Resident #53 had the potential to affect Resident #53 by the deficient practice. Resident #53 had no negative outcome due to the deficient practice. All residents have the potential to be affected by the deficient practice. All Resident's Physician Orders for a Urine Analysis with reflex and Complete Blood Count laboratory test were audited on	3/12/20

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

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F 770	Continued From page 1 placed in the appropriate systems for implementation. Review of Resident #53's Departmental Notes, dated 01/20/2020 at 1:50 PM, revealed the resident was noted with increased confusion with orders to obtain a U/A with Reflex. An entry made on 01/28/2020 at 11:25 PM revealed the U/A was collected, which was eight (8) days later. A review of Resident #53's physician orders, dated 01/20/2020, revealed an order to "Obtain Urine for U/A with Reflex to Culture and Sensitivity (C&S) related to confusion. The order was received and entered into the computer by Licensed Practical Nurse (LPN) #2. Review of the "24-Hour Nursing Report" dated 01/20/2020, revealed Resident #53 needed a U/A. On 02/12/20 at 9:15 AM, during an interview with the Director of Nursing (DON), she stated, "I'm not sure why the specimen was not collected for that long." The DON stated the nurse on the 11 PM to 7 PM shift was responsible for starting the 24 hour report and carrying over everything that should be on it. During an interview, with the Nurse Practitioner, on 02/12/2020 at 4:15 PM, she stated, "I would like for the order to be completed within a few days to get the results back to start treating." On 02/13/2020 at 10:30 AM, during an interview, Licensed Practical Nurse (LPN) #2, revealed she received the order for the U/A on 01/20/2020 due to Resident #53 seemed more confused and sleepy. LPN #2 revealed she placed Resident	F 770	02/18/2020 by the Medical Records Staff and the Assessment Nurse for three (3) months prior to 02/01/2020. The results of the audit for the laboratory services were no problems noted. Medical Records Staff and the Assessment Nurse continued the audit for a Urine Analysis with reflex and Complete Blood Count laboratory test for February 2020 and the results were no problems. All Nurses were in-serviced on 02/12/2020 by the Director of Nursing or the Infection Preventionist Nurse regarding Physician Orders with emphasis on new laboratory orders and laboratory services of collection, receiving the lab report and reporting results to the Physician/Nurse Practitioner. The lab tracking book will be completed upon receiving a Physician Lab Order and reviewed in the daily stand up meeting for correctness by the Director of Nursing, Medical Records Staff, and the Infection Preventionist Nurse. All lab orders will be reviewed by the Infection Preventionist Nurse on a daily basis beginning 02/17/2020 by bringing the lab tracking book to the Daily Stand Up Meeting and reviewing any lab orders daily for a period of four (4) weeks then bi-weekly for a period of four (4) weeks then monthly for one (1)month or until resolved. The Director of Nursing, Medical Records Staff, and the Infection Preventionist will address any concerns and update the corrective action when needed. The Quality Assurance Committee will address any concerns and	

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F 770	Continued From page 2 #53 on the bedpan for 20 minutes that day, but was unable to get the sample. LPN #2 stated, "I forgot to chart that." Review of the "Face Sheet" revealed, Resident #53 was admitted by the facility, on 01/09/2020, with diagnoses of Type 2 Diabetes Mellitus, Peripheral Vascular Disease, Chronic Ischemic Heart Disease, Hypertension and Osteoarthritis.	F 770	update the corrective action when needed.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control 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 §483.70(e) 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:	F 880		3/12/20

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F 880	Continued From page 3 (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 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:	F 880		

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F 880	Continued From page 4 Based on observation, staff interview, and facility policy review, the facility failed to prevent the potential spread of infection during medication administration, for one (1) of five (5) residents observed during medication pass. Findings include: Review of the facility's "General Infection Prevention and Control Nursing Policies", dated 06/2014, revealed: "It is the policy of this facility that all nursing activities will be performed in a manner to minimize the potential for infection in residents, staff, and visitors. On 02/11/2020 at 8:39 AM, during an observation and interview, with Licensed Practical Nurse (LPN)#1 took a bottle of Artificial Tears and a Ventolin inhaler into Resident #7's room and placed them on the resident's over-the-bed table without the use of a barrier or disinfection of the table. LPN #1 stated, "I should have cleaned them before I put them back in the cart or used a barrier." LPN#1 confirmed the medication cart was contaminated by this action. On 2/12/2020, at 9:05 AM, during an interview with the Director of Nursing (DON), she stated LPN #1 should have used a barrier or cleaned the items with a germicidal cloth prior to placing them back into the medication cart. The DON revealed this was an infection control problem.	F 880	Licensed Practical Nurse #1 was in-serviced on 02/11/2020 on General Infection Prevention and Control Nursing Policy by the Director of Nursing. Resident #7 had no adverse effect of a barrier not being placed between the over-bed table and the inhaler medication. All residents have the potential to be affected by the deficient practice. All Licensed Practical Nurses and Registered Nurses were in-serviced on the Policy of Infection Prevention and Control Nursing Policy, the Policy of Drug Administration and Documentation and Laboratory Services by the Director of Nursing on 02/26/2020. The Pharmacy Consultant visited and performed a medication pass with Licensed Practical Nurse #1 on 01/20/2020 and had no medication errors and no other issues. All medication nurses will be observed weekly beginning 02/24/2020 by the Director of Nursing or the Infection Preventionist Nurse on infection control prevention with medications by using the Corrective Action Plan weekly for a period of four (4) weeks then bi-weekly for a period of four (4) weeks then once a month for one (1) month. All findings will be reported to the Quality Assurance Committee. The Quality Assurance Committee will address any concerns and update the corrective action when needed.	

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	255279	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/10/2020**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to properly inspect fire doors as required by S&C Letter 17-38. This deficiency practice affected one (1) of five (5) smoke compartments and 14 of 60 residents in the facility on the day of survey. Findings include: On 2/11/2020 at 11:00 AM, observation revealed one (1) stairwell fire door in the facility. The facility could not provide documentation showing the annual inspection of the fire door in the facility. The one (1) stairwell fire door was located near Rooms 101 and 102 of the facility.	K 211	The Fire Rated Metal Door in the storage area separating the Nursing Facility and the attached building was inspected on 02/21/2020 by the Administrator and Maintenance Staff to ensure the requirements for a fire rated metal door were met. Residents residing in the facility have the potential to be affected by the deficient practice. Facility Administrator in-serviced the Maintenance Staff on 02/21/2020 on the requirements for inspecting the fire rated metal door. The fire rated metal door will be inspected annually and results recorded on the Annual Fire Door	3/12/20

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 211	Continued From page 1	K 211	Inspection Sheet. The Maintenance Staff will make rounds monthly for 3 months and then annually to ensure the fire rated metal door is closing properly and the fire rated metal door is meeting the requirements for inspection. Results of the rounds will be recorded and reviewed by the Administrator.The Quality Assurance Committee will review the results of the rounds monthly and at the next scheduled quarterly Quality Assurance Committee meeting in April 2020.	

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	255279	A. BUILDING **02 - SARDIS COMMUNITY NURSING HOME** B. WING _____	**02/10/2020**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 2/10/20 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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