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	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sardis Community NH	613 East Lee Street Sardis, MS 38666

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review, and facility policy review, the facility failed to ensure a resident was 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. Findings Include:Cross-Reference F610Review 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 .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.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 involving Resident #1 on 9/17/25.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.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.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 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.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 An interview with CNA #1 on 12/23/25 at 11:15 AM revealed she was assigned to care for Resident #1

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review, and facility policy review, the facility failed to ensure an allegation of abuse was thoroughly investigated for one (1) of five (5) residents reviewed. (Resident #1) Findings Include:Cross-Reference F600Review of the facility policy titled Incident Investigation & Reporting, revised 5/24, revealed, .6 The facility will thoroughly investigate all alleged violations under the direct supervision of the Administrator. The facility will take all necessary steps to prevent occurrence and/or further potential abuse.Record review revealed an allegation of abuse involving Resident #1 was reported on 9/17/25 after staff responded to the resident screaming for help and observed the resident on the floor following an altercation with Nurse Aide #1.Record review of the Incident Description dated 9/17/25 revealed, Summoned to room per CNA (certified nurse aide) and housekeeper. Upon entering room with charge nurse present, resident sitting on floor in front of wheelchair and CNA (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.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.On 12/23/25 at 11:15 AM an interview with Certified Nurse Aide (CNA) #1 revealed she heard Resident #1 screaming Stop, stop, stop, and observed the resident on the floor with Nurse Aide #1 yelling at him to get up and spraying his legs with an aerosol substance. CNA #1 stated she wrote a witness statement regarding the incident and provided it to administration.On 12/23/25 at 11:41 AM an interview with Registered Nurse (RN) #1 revealed she observed Resident #1 on the floor with Nurse Aide #1 sitting in a chair laughing and stated she wrote a witness statement and submitted it to administration.On 12/23/25 at 1:17 PM a telephone interview with Licensed Practical Nurse (LPN) #1 revealed she observed Resident #1 on the floor while Nurse Aide #1 was sitting in a chair laughing. LPN #1 further stated, Nurse Aide #1 sprayed the resident's legs with air freshener and threw personal items from the bedside table into the garbage can. LPN #1 stated she wrote a witness statement and provided it to administration.Record review of the facility's abuse investigation dated 9/17/25 revealed the Administrator determined the allegation of abuse could not be substantiated due to an inability to prove intent. Further record review of the abuse investigation file revealed witness statements from CNA #1, RN #1, and LPN #1 were not included in the investigation documentation, demonstrating the witness statements were excluded from the investigation. On 12/23/25 at 1:38 PM an interview with the Administrator (ADM) revealed she believed the incident involving Resident #1 and Nurse Aide #1 was accidental and stated conflicting accounts prevented substantiation of abuse. She stated she could not prove Nurse Aide #1 showed intent to harm Resident #1. The Administrator acknowledged her determination was not supported by the totality of evidence obtained and that conflicting accounts were used to dismiss the allegation.Record review of the admission Record revealed Resident #1 was admitted on [DATE] with diagnoses including urinary tract infection, hypertensive urgency, and hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side.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.