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	03/19/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review, interview, and facility policy review, the facility failed to develop and implement a comprehensive, person-centered care plan to address a newly identified skin breakdown to the sacrum for one (1) of three (3) residents reviewed (Resident #1).Findings included:Record review of facility policy titled, Care Plan Process, revised 12/24 revealed .The Care Plan must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, on an ongoing basis to reflect the services provided or arranged and must be consistent with each resident's written plan of care .Record review of the Care Plan Report for Resident #1 revealed no care plan had been developed related to the excoriated area to the sacrum.Record review of Progress Notes dated 2/15/26 confirmed the presence of a new excoriated area to the sacrum requiring treatment and monitoring.Interview on 3/19/26 at 12:07 PM with Registered Nurse #1 (RN) revealed that the purpose of the care plan was to ensure staff were aware of how to care for the resident.Interview on 3/19/26 at 1:05 PM with the Minimum Data Set (MDS) Nurse confirmed that no care plan was developed for the newly identified skin breakdown area to the sacrum but acknowledged that one should have been implemented.Record review of the Face Sheet for Resident #1 revealed that the facility admitted the resident on 5/22/2019 with diagnoses of Diabetes Mellitus and Cerebral Infarction.

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on record review, interview, and facility policy review, the facility failed to ensure that a resident who developed skin breakdown to the sacrum received ordered treatment services to promote healing and prevent further skin breakdown for one (1) of three (3) residents reviewed for pressure ulcers. (Resident #1).Findings included:Review of facility policy titled, Prevention and Treatment of Skin Issues, latest review date 09/25 revealed Policy: It is the policy to properly identify and assess resident whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care .Record review of Progress Notes for Resident #1, dated 2/15/26, revealed the resident was noted with an excoriated area to the sacrum that was slightly reddened with no drainage. The note indicated the Director of Nursing (DON), wound care nurse, and Responsible Party were notified and a new order was obtained to cleanse the area with wound cleanser, pat dry, and apply zinc oxide.Record review of the Order Summary Report for Resident #1 revealed an order dated 2/15/26, to cleanse the excoriated area to the sacrum with wound cleanser, pat dry, and apply zinc oxide every shift until healed.Record review of the February 2026 Medication Administration Record (MAR) and Treatment Administration Record (TAR) for Resident #1 revealed there was no documentation that the ordered treatment dated 02/15/26 to the sacrum was provided.Interview on 3/19/26 at 12:00 PM, with Registered Nurse #1 (RN) revealed that a Certified Nursing Assistant (CNA) notified her of the skin issue on 2/15/26. She stated she assessed the resident, identified a red excoriated area, and obtained treatment orders, which she entered into the system and expected to trigger on the MAR/TAR.Interview and concurrent record review on 3/19/26 at 12:03 PM, with RN #1 confirmed there was no documentation that the ordered treatment was provided. RN #1 stated she did not know why the treatment had not triggered and agreed that failure to perform the treatment could have caused worsening of the area.Interview on 3/19/26 at 12:30 PM, with the DON revealed that daily review of orders is conducted; however, the treatment order for Resident #1 was missed. The DON further stated the order did not trigger to the MAR/TAR because an incorrect order type was selected when the order was put into the system on 02/15/26.Record review revealed that Resident #1 was sent out to the Emergency Department on 02/18/26 for a change in level of consciousness and never returned to the facility and was discharged from the facility on 02/25/26. Record review of the Face Sheet for Resident #1 revealed that the facility admitted the resident on 5/22/2019 with diagnoses of Diabetes Mellitus and Cerebral Infarction.