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	07/23/2024

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47874 Based on record review, staff interview, and facility policy review, the facility failed to complete and submit a Discharge Tracking Minimum Data Set (MDS) resident assessment to the Centers for Medicare and Medicaid Services (CMS) for a resident who transferred to an acute care facility for one (1) of 16 MDS's reviewed. Resident # 38. Findings Include: Review of the facility policy titled MDS Process with a revision date of 12/20 revealed, The RAI (Resident Assessment Instrument) is the source document to be used for further MDS coding guidelines, time schedules and requirements. Record review of the Progress Notes revealed Resident #38's was transferred to a behavioral health center on 6/25/24 and returned to the facility on [DATE]. Record review of Resident #38's MDS Assessments revealed a discharge tracking assessment was not completed after Resident #38 was transferred to a behavior health center. An interview with the Director of Nursing (DON) on 7/23/2024 at 2:45 PM, confirmed the MDS discharge tracking assessment for Resident #38 was not completed, and it should have been done. An interview with the MDS Nurse on 7/23/2024 at 3:19 PM, confirmed Resident #38 did not have a discharge tracking assessment completed following the transfer to behavioral health. She revealed the facility was in the process of changing over charting systems at the time the assessment was due, and she missed it. She confirmed this should be done for tracking purposes. Record review of the Admission Record revealed the facility admitted Resident #38 on 11/23/2021 and has diagnoses that include Senile degeneration of the brain.

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 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. 45598 Based on observation, staff interview, record review, and facility policy review, the facility failed to implement a care plan for nail and oral care (Resident #31) and failed to develop an individualized resident specific comprehensive care plan that identified potential fears, triggers, and/or behavioral expressions along with interventions for a resident with Post Traumatic Stress Disorder (PTSD) (Resident #37) for two (2) of 16 care plans reviewed. Findings Include: Record review of the facility policy, Care Plan Process with revision date of 08/17 revealed .Step 9 .The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs, including culturally competent and trauma-informed as well as, these items or services that would be required but are not due to the exercise of resident rights (refusal) .The facility staff shall follow the care plan . Record review of Resident #31's Care Plan, with no problem onset date, revealed Resident has a dx (diagnosis) of Hemiplegia/Hemiparesis to right side .Approaches .Assist resident with ADLS (Activities of Daily Living) as needed . On 07/22/24 10:00 AM, an observation of Resident #31 revealed he was lying in bed, alert, with his mouth open and his teeth had yellow substance covering all teeth. Observation also revealed brown substance under the fingernails of his left hand. On 07/23/24 at 9:45 AM, an observation with Licensed Practical Nurse (LPN) #1, revealed Resident #31 lying in bed with a yellow substance covering his teeth and a brown substance under the fingernails of his left hand. LPN #1 confirmed that Resident #31 had yellow buildup on his teeth and revealed this could cause tooth decay and other problems with his mouth. On 07/23/24 at 12:30 PM, an interview with DON, revealed that the purpose of the care plan was to show the care that each resident needed so the staff knew how to meet each resident's individual needs. She agreed that the staff did not follow the care plan when they failed to provide oral and nail care for Resident #31. 47874 Resident #37 Record review of Resident #37's Care Plan revealed, Problem Onset: Resident has a DX (diagnosis) of Post Traumatic Stress Disorder/Emotional Trauma. The approaches were not individualized and did not address potential triggers/fears related to her history of trauma. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility Social Assessment for Resident #37, dated 5/1/2024 revealed, Resident #37 had not experienced a traumatic event in the past, trauma-related symptoms, nor any impact to her daily routine. An interview with Social Services (SS) #1 on 7/23/2024 at 10:45 AM, revealed Resident #37 did have inappropriate touching behaviors and would touch residents and staff. An interview with LPN #2 on 7/23/2024 at 2:40 PM, confirmed she was aware that Resident #37 had a diagnosis of PTSD, and revealed the resident did not like people to hug her. An interview with the Director of Nursing (DON) on 7/23/2024 at 2:53 PM, confirmed a comprehensive resident specific care plan was not developed to include Resident #37's fears and possible triggers for re-traumatization and behavior expressions staff should be aware of. She revealed the care plan was not developed because the trauma informed care assessment was not completed. An interview with the Minimum Data Set (MDS) Nurse on 7/23/2024 at 3:45 PM, revealed the purpose of the care plan was to know how to care for the resident. She confirmed the care plan for Resident #37 was not individualized and did not address possible triggers or resident specific approaches for PTSD.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on observation, staff interview, and facility policy review the facility failed to provide Activities of Daily Living as evidenced by failure to provide daily oral care and nail care for one (1) of 16 residents reviewed. (Resident #31) Findings Included: Record review of the facility policy, Oral Hygiene with revision date of 10/17 revealed Purpose: To clean the mouth, teeth, gums .To remove bacteria and odor . Procedure .1. Offer oral hygiene before breakfast, and at bedtime . Record review of the facility policy, Nail Care with review date of 01/24 revealed Purpose: To promote cleanliness, safety and a neat appearance . Procedure .7. Remove any debris from under the nails with the orangewood stick . On 07/22/24 at 10:00 AM, an observation of Resident #31 revealed he was lying in bed, alert with his mouth open and a yellow substance covering all of his teeth. An observation of his hands revealed a brown substance under the fingernails of his left hand. On 07/23/24 at 9:45 AM, an observation with Licensed Practical Nurse (LPN) #1, revealed Resident #31 lying in his bed with a yellow substance covering his teeth and a brown substance under the fingernails of his left hand. LPN #1 confirmed that he had yellow buildup on his teeth and revealed this could cause tooth decay and other problems with his mouth. She revealed that the Certified Nursing Assistants (CNA)s were supposed to do mouth care every day and usually did this during their morning rounds while they were doing their baths. LPN #1 revealed they used mouth swabs to clean Resident #31's teeth because they were afraid of aspiration if they tried to brush his teeth. She agreed that Resident #31's mouth care had not been done. LPN #1 also confirmed the brown substance under the fingernails of Resident #31's left hand and stated, I will find some clippers and do the nails now. She revealed that they scheduled fingernails to be clipped every Sunday, but nails should be looked at every day and checked for cleanliness. LPN #1 agreed dirty fingernails could cause infection if he scratched himself and the CNAs should have taken care of this. On 07/23/24 at 9:50 AM, an interview with Director of Nursing (DON), revealed mouth care was supposed to be completed at least once a day. She revealed the CNAs were responsible for completing mouth care and they used mouth swabs if the residents couldn't tolerate brushing their teeth. The DON confirmed personal hygiene included nail care and mouth care. She revealed that the CNAs were responsible for checking fingernails and this should be done every day. She also revealed that failure to provide nail care and oral care was unacceptable and could cause sores in the mouth, tooth decay and other problems. The DON stated, This makes me angry. Record review of Resident #31's Face Sheet revealed an admitted [DATE] and included diagnoses of Parkinson's Disease, Dysphagia following Cerebral Infarction, and Cognitive Communication Deficit.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 47874 Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to complete a Trauma Informed Care Assessment for a resident with a diagnosis of Post Traumatic Stress Disorder (PTSD) for one (1) of 1 resident reviewed for Trauma Informed Care. Resident #37 Findings Include: Review of the facility policy titled Social Documentation - Progress Notes with a revision date of 10/23 revealed under, Policy: Social Progress Notes should be entered into the resident's Medical Record during the observation period of each MDS (Minimum Data Set) and whenever unusual circumstances occur, or for changes in resident condition or status. An observation and interview with Resident #37 on 7/22/2024 at 12:35 PM, revealed she was sitting in a wheelchair in her room. Resident was verbal with few words and stated, I'm fine. Record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/2/2024 revealed, under section I, Resident #37 has a medical diagnosis of PTSD. Also revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicates the resident is cognitively intact. An interview with Social Services #1 (SS) on 7/23/2024 at 10:45 AM, explained that social assessments were due quarterly, and Resident #37 was upcoming but had not been completed yet. SS #1 confirmed she was aware that Resident #37 had a history of traumatic events, and revealed she was notified upon starting the social services position. She revealed to her knowledge the resident was diagnosed with PTSD after she was sent for a behavioral health stay and confirmed the facility did not have a social assessment that identified she had a traumatic history. Record review of Resident #37's Psychiatric Evaluation from the behavior health stay, dated 8/20/2022, revealed (Traumatic event) as a teen. States has bad dreams about it a lot. Also revealed under, Plan: Add Zoloft (anti-depressant) .daily for questionable PTSD symptoms. Record review of the facility Social Assessment for Resident #37, dated 5/1/2024 revealed, Resident #37 had not experienced a traumatic event in the past nor experienced any trauma-related symptoms. An interview with Licensed Practical Nurse (LPN) #2 on 7/23/2024 at 2:40 PM, revealed she was the nurse caring for Resident #37 today. She confirmed she was aware that the resident had a diagnosis of PTSD and revealed the resident did not like people to hug her. An interview with the Director of Nursing (DON) on 7/23/2024 at 2:53 PM, confirmed Resident #37 did not have a trauma informed care assessment completed to address the resident's diagnosis of PTSD and revealed it should have been done to address any symptoms and possible triggers. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Admission Record revealed the facility admitted Resident #37 on 6/25/21 with medical diagnoses that included Personal history of traumatic brain injury and Unspecified convulsions. A medical diagnosis of Post-Traumatic Stress Disorder was added to the resident's diagnoses list on 8/26/2022.