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	07/01/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, staff and resident interviews, record review and facility policy review, the facility failed to provide a homelike environment for one (1) of 55 residents residing in the facility. Resident #40. Findings include: Review of the facility policy titled, Resident Environment, dated 9/15 with no revision date revealed, It is the policy of this facility to provide a safe, clean, comfortable and homelike environment . During an observation on 6/29/25 at 4:00 PM, it was noted that Resident #40's room had an approximate two feet by four feet area of paint missing from the wall across from the bathroom door. The resident expressed concern, stating, It's been that way since I moved in here. Sometimes my family comes to visit me. I wouldn't have my home looking like that. During an observation and interview with the Maintenance Director on 6/30/25 at 12:52 PM confirmed that he was aware of the missing paint and stated, I just haven't got around to it. He further remarked, I wouldn't want my house to look like that, and this is their home and that they are supposed to be provided with a homelike environment. During an interview with the Administrator on 6/30/25 at 12:54 PM, she acknowledged the facility's responsibility to maintain a homelike environment and admitted to failing to notice the issue during her rounds. Record review of the admission Record revealed that the facility admitted Resident #40 on 5/6/22. Record review of the quarterly MDS (Minimum Data Set) with an Assessment Reference Date (ARD) of 5/14/25 under Section C, revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating that the resident had moderate cognitive impairment.

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

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	07/01/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, staff interviews, record reviews, and facility policy review, the facility failed to accurately code an admission Minimum Data Set (MDS) assessment for one (1) of 18 resident MDS assessments reviewed. Resident #52 Findings include: Review of facility policy titled, Resident Assessment, last revised on 9/19, revealed, .The completed assessment guide the staff in identifying key information about the resident and serves as a basis for identifying resident specific issues and objectives in order to develop a care plan .healthcare professional that completes a portion of the assessment must sign and certify the accuracy of the portion of the assessment that they have completed . Record review of Resident #52's admission MDS, section P, with an Assessment Reference Date (ARD) of 4/29/25, revealed that the bed rails were coded as a restraint. Record review of Resident #52's Care Plan titled, Resident's Current Safety Devices and Special Equipment dated 4/22/25 revealed, .Side Rails x (times) two (2) .for bed mobility . An observation of Resident #52's bed on 6/29/25 at 5:04 PM revealed that half side rails were attached. During an interview on 6/30/25 at 9:55 AM with the MDS Coordinator, she acknowledged that Resident #52's bedrails were incorrectly coded, stating the bed rails were used for positioning rather than as a restraint. During an interview with the Director of Nursing (DON) on 7/01/25 at 12:10 PM, she expressed her expectation that MDS assessments accurately reflect the resident's condition and concurred that the bed rails should not have been coded as restraints, emphasizing that they were intended to assist with positioning. She firmly stated, We do not have restraints in this building. Record review of the admission Record revealed that the facility admitted Resident #52 on 4/22/25 with medical diagnoses that included Traumatic Hemorrhage of Left Cerebrum with Loss of Consciousness Status Unknown. Record review of the admission MDS with an ARD of 4/29/25 under Section C, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating that the resident had severe cognitive impairment.

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	07/01/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on staff and resident interviews, record reviews and facility policy review, the facility failed to develop a comprehensive care plan for a resident taking an anticoagulant (Resident #32) and failed to implement an Activities of Daily Living (ADL) care plan (Resident #257) for two (2) of 26 resident's care plans reviewed. The scope for F656 was increased to E to indicate a pattern of noncompliance due to a prior citation during the last recertification survey 7/23/24. Findings include: Review of the facility policy titled, Care Plan Process with review date 12/24, revealed, .the facility shall develop and implement .care plan .for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care . Resident #32 Record review of Resident #32's Physician's Orders revealed an order with a start date of 4/7/25 for Apixaban Oral Tablet 5 milligrams (mg); Give 1 tablet by mouth two times a day related to Acute Embolism and Thrombosis of Unspecified Femoral Vein. Record review of Resident #32's care plans revealed that a comprehensive care plan had not been developed for anticoagulant therapy. During an interview on 6/30/25 at 11:00 AM with the Minimum Data Set (MDS) Coordinator, she confirmed that a comprehensive care plan addressing the risk for bleeding associated with anticoagulant therapy was absent. She emphasized the critical nature of this oversight, stating that a care plan should have been initiated at the same time the anticoagulant order was entered to ensure proper monitoring. The MDS Coordinator expressed serious concerns, noting that the resident could die if active bleeding occurred and went unnoticed due to the lack of monitoring protocols. During an interview with the Director of Nursing (DON) on 7/01/25 at 12:04 PM, she reiterated her expectation that a comprehensive care plan must be developed whenever an anticoagulant is prescribed for a resident. She highlighted the potential consequences of failing to implement such a plan, indicating that a resident could experience a bleed that might go undetected, potentially leading to hospitalization or worse outcomes. Record review of the admission Record revealed that the facility admitted Resident #32 on 3/31/25 with medical diagnoses that included Acute Embolism and Thrombosis of Unspecified Femoral Vein. Record review of the quarterly MDS with an Assessment Reference Date (ARD) of 4/16/25 under Section C revealed, a Brief Interview for Mental Status (BIMS) score of 15, indicating that the resident was cognitively intact. Resident #257 (continued on next page)

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	07/01/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview with Resident #257 on 6/29/25 at 4:58 PM, revealed that Resident #257 had a foul odor and stated he had not had a bath or shower since his admission. Record review of the Care Plan Report for Resident #257 revealed: The resident needs assistance with ADLs (Activities of Daily Living) Date initiated 6/27/25 .Interventions: . The resident needs partial/moderate assist to transfer with bathing/showering . During an interview with the MDS Coordinator, on 6/30/25 at 2:45 PM, she stated, The purpose of a care plan is to make sure that staff addresses and provides the care for each resident for their specific care needs. On 7/01/25 at 10:22 AM, the DON stated, The purpose of a care plan is to provide person-centered care. Record review of Resident #257's admission Record revealed the facility admitted the resident on 6/16/25 with medical diagnoses that included Parkinson's Disease with Dyskinesia, with fluctuations. Record review of Resident #257's MDS with an ARD of 6/23/25 under Section C, revealed a BIMS score of 15, indicating that Resident #257 was cognitively intact.

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	07/01/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interviews, record review and facility policy review, the facility failed to ensure that assistance with Activities of Daily (ADL) was provided to a resident that required assistance with bathing for one (1) of 26 sampled residents. Resident #257 Findings Include: Review of the facility's policy titled, Activities of Daily Living with a revision date of 11/24, revealed under Policy: Activities of Daily Living will be documented on a daily basis by the CNA (Certified Nursing Assistant) to reflect actual care rendered to the resident. The ADL shall become a permanent part of the residents' chart . 2. ADLS shall include, but are not limited to .bathing . On 6/29/25 at 4:58 PM, an observation of Resident #257 revealed a foul odor. An interview with Resident #257, revealed that he had not received a bath or shower since his admission two weeks ago. During an observation and interview on 6/30/25 at 11:00 AM, the resident was observed wearing the same pants as the day before and continued to have a foul odor. Resident #257 stated that he had not gotten a bath or shower this morning. His brother, who is also his roommate, stated that he had not seen Resident #257 get a bath or go to the shower room since his admission. An interview with 6/30/25 at 2:00 PM with CNA #1, revealed that she helps on the hall, and that Resident #257 is scheduled to receive a bath on Mondays, Wednesdays, and Fridays. She stated, I can't remember when he had a bath or shower. She attempted to locate documentation but was unable to provide any dates. Record review of the Kardex Follow Up Question Report 6/16/25 through 6/30/25 revealed documentation of personal hygiene, but there were no notations of a bath or shower in the record. During an interview on 6/30/25 at 2:15 PM with Licensed Practical Nurse (LPN) #1, she stated, I don't recall when he received a bath or shower. She also stated, He has never refused care with me. On 7/01/205, an interview with the Director of Nursing (DON), confirmed that Resident #257 should have received a bath or shower on Mondays, Wednesdays, and Fridays. Record review of Resident #257 admission Record revealed the facility admitted Resident #257 on 6/16/2025 with diagnoses including Parkinson's Disease. Record review of Resident #257 Minimum Data Set (MDS), Section C, with an Assessment Reference Date (ARD) of 6/23/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #257 is cognitively intact.

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	07/01/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on staff interviews, record reviews, and facility policy review, the facility failed to monitor the adverse effects of an anticoagulant medication for one (1) of five (5) residents reviewed for unnecessary medications. Resident #32. Findings include: Review of facility policy titled, Drug Administration and Documentation with last review date 3/25, revealed, . Residents shall be observed for adverse effects such as side effects, interactions, and allergic reactions. The physician shall be notified of any adverse effects that occur . Record review of Resident #32's Physician's Orders revealed an order with a start date of 4/7/25 for Apixaban Oral Tablet 5 milligrams (mg); Give 1 tablet by mouth two times a day related to Acute Embolism and Thrombosis of Unspecified Femoral Vein. Record review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for Resident #32 for June 2025, it was noted that there was no monitoring protocol in place for the side effects associated with an anticoagulant therapy. During an interview with Licensed Practical Nurse (LPN) #2 on 6/30/25 at 10:12 AM, she revealed there were no specific orders in place for monitoring the risk for bleeding related to the anticoagulant medication. The LPN emphasized the need for monitoring to detect active bleeding and/or excessive bruising, highlighting the potential for severe complications, such as hospitalization due to bleeding or low hemoglobin (Hgb) and hematocrit (Hct) levels. During an interview on 6/30/25 at 11:00 AM with the Minimum Data Set (MDS) Coordinator, she confirmed that monitoring for the risk of bleeding associated with anticoagulant therapy was absent. She stressed the importance of implementing monitoring tasks concurrently with the initiation of the anticoagulant order to ensure effective oversight. The MDS Coordinator expressed serious concerns, stating that without proper monitoring, the resident could die if active bleeding occurred and went unnoticed due to the lack of established protocols. The Director of Nursing (DON) during an interview on 7/01/25 at 12:04 PM, revealed that monitoring for bleeding should commence whenever an anticoagulant is prescribed for a resident. She underscored the potential consequences of failing to implement such a monitoring plan, indicating that undetected bleeding could lead to significant health risks and possible hospitalization. Record review of the admission Record revealed the facility admitted Resident #32 on 3/31/25 with medical diagnoses that included Acute Embolism and Thrombosis of Unspecified Femoral Vein. Record review of the quarterly MDS with an Assessment Reference Date (ARD) of 4/16/25 under Section C, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating that the resident was cognitively intact.

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	07/01/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on staff interviews, record review, and facility policy review, the facility failed to document wound treatments for a resident with a Stage 3 pressure ulcer for one (1) of three (3) residents with wounds reviewed. Resident #36 Findings include: Record review of facility policy titled, Physician Orders with a revision date of 01/25, revealed, It is the policy of this facility that all physician's orders will be implemented timely and carried out in a professional manner. Licensed nurses are responsible for following physician orders. Record review of Electronic Treatment Administration Record (ETAR) for April 2025 and May 2025 revealed an order with a start date of 4/15/25 and a discontinue date (D/C) date of 5/9/25 to Clean pressure ulcer stage 2 to sacral with wound cleanser. Pat day. Apply mupirocin and collagen to wound and cover with foam dressing daily until healed. Treatments for 4/19/25, 4/21/25, 4/27/25, 5/2/25, and 5/9/25 were not documented as administered. Record review of ETAR for May 2025 revealed an order with a start date of 5/10/25 and a D/C date of 5/23/25 to Cleanse with wound cleanser and apply Dakins wet to dry x 2 weeks and then rephotograph one time a day for treatment. Treatments for 5/18/25, 5/21/25, and 5/22/25 were not documented as administered. Record review of ETAR for May 2025 and June 2025 revealed an order with a start date of 5/24/25 and a D/C date of 6/5/25 to Clean wound to sacral area with wound cleanser. Pat dry. Apply mupirocin and alginate to wound and cover with bordered dressing every day until healed. Treatments for 5/25/25, 5/29/25, 6/2/25, and 6/4/25 were not documented as administered. Record review of ETAR for June 2025 revealed an order with a start date of 6/6/25 and a D/C date of 6/10/25 to Clean wound to sacral area with normal saline, pat dry, apply mupirocin, hydrofera blue, calcium alginate and cover with foam dressing daily and PRN (as needed) when soiled until healed. Treatment for 6/8/25 was not documented as administered. Record review of ETAR for June 2025 revealed an order with a start date of 6/11/25 to Clean Stage 3 pressure injury to sacral area with normal saline, pat dry, apply mupirocin, hydrofera blue, calcium alginate and cover with foam dressing daily and PRN when soiled until healed. Treatments for 6/21/25 and 6/22/25 were not documented as administered. On 06/30/25 at 11:00 AM, wound treatment observation and interview with Registered Nurse (RN) #2 revealed wound management services visits weekly on Wednesdays. She revealed she started at the facility in April 2025 and Resident #36 had a little bit of breakdown and we were treating it then and now it is looking much better with pink granulation. This observation confirmed the wound had pink granulation. (continued on next page)

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	07/01/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 6/30/25 at 12:20 PM, the Director of Nurses (DON) confirmed that after reviewing the ETAR for Resident #36's wound treatment, there were fifteen days with missing documentation for the months of April, May, and June. She revealed that it is our expectation that all treatments are documented in the system, and if another nurse goes in to render treatment and finds a bandage with an old date, they will report it to me. She revealed I just can't imagine that my nurses wouldn't do a treatment, I think they have gotten busy and failed to document in the ETAR. She revealed that documenting care is part of the continuity of care, and treatments should be done and documented accurately. During an interview on 6/30/25 at 4:35 PM, Licensed Practical Nurse (LPN) #3 revealed she used to be the wound treatment nurse and still helps with treatments at times. She revealed she has not seen where treatments haven't been done. She revealed that if she had noticed a wound bandage with an old date then she would have reported that to the DON. She revealed that she thinks the nurses failed to document the care that they did. She revealed that she has honestly forgot to document treatment a few times herself. In an interview on 6/30/25 at 4:59 PM, Registered Nurse (RN) #2 revealed that she is the treatment nurse and works Monday-Friday. She revealed she is new as the treatment nurse and tries to ensure she documents in the system when she provides care. She revealed that she was not sure about the weekend nurses' documentation. Record review of Resident #36's admission Record revealed the facility admitted the resident on 5/8/24 with diagnoses which included Chronic Kidney Disease, Stage 4, and Dementia. Record review of Minimum Data Set (MDS) Section C with Assessment Reference Date (ARD) of 5/27/25 revealed that Resident #36 was rarely or never understood.

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	07/01/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record reviews, and facility policy review, the facility failed to prevent the potential spread of infection by not ensuring staff performed proper hand hygiene during three (3) of nine (9) direct care observations. Specifically, staff failed to perform hand hygiene before and after medication administration and during wound care procedures, which poses a risk of cross-contamination and infection transmission. Findings include: Review of the facility policy titled, Hand Hygiene with a revised date of 1/24 revealed the following: Purpose: To cleanse hands to prevent transmission of infection or other conditions . 2. Hand hygiene should be performed between all contact with residents or when entering and exiting a resident's room . Review of the facility policy titled, Dressing Change Policy and Procedure with a revised date of 3/14, revealed the following: .9. Put on disposable gloves. 11.Remove dressing. Pull gloves over dressing and discard them into appropriate plastic waste bag. 12. Perform hand hygiene. Put on disposable gloves. 13. Irrigate/cleanse the area as ordered . 16. Perform hand hygiene. Apply disposable gloves . 18. Dress the area with the prescribed dressing . An observation on 6/30/25 at 7:35 AM revealed that Licensed Practical Nurse (LPN) #1 failed to wash her hands prior to setting up the medications from the medication cart, entered resident room [ROOM NUMBER]A and administered the medications without washing her hands. LPN #1 exited the room and failed to wash her hands or use hand sanitizer before setting up the medication for resident room [ROOM NUMBER]B. LPN #1 entered resident room [ROOM NUMBER]B and administered medications without washing her hands. An interview on 6/30/25 at 7:50 AM, LPN #1 confirmed that she didn't wash or sanitize her hands before setting up or administering both residents' medications. She confirmed that she should have practiced hand hygiene to prevent cross-contamination and prevent infections. LPN #1 stated, I guess I need to go up front and get myself a bottle of hand sanitizer for my cart. On 6/30/25 at 11:00 AM, an observation of wound care provided by Registered Nurse (RN) #2 revealed that RN #2 gathered her supplies, entered Resident #36's room, washed her hands, and donned gloves. RN #2 removed the soiled bandages from the sacral wound, proceeded with the wound treatment and cleaned the sacral wound with normal saline. She then patted dry with a 4x4 gauze, applied mupirocin, covered with hydrofera blue and calcium alginate, and covered the sacral wound with a clean foam dressing. This observation revealed RN #2 did not change gloves or perform hand hygiene between the dirty and clean steps of the wound care procedure. On 6/30/25 at 11:15 AM, RN #2 confirmed that she removed Resident #36's dirty wound dressings, cleaned her wound, and then administered her wound treatment, which included a clean dressing without changing her soiled gloves, washing her hands, and applying clean gloves in between the dirty and clean wound treatment process. She revealed this could contaminate the wound and prevent healing. (continued on next page)

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	07/01/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/30/25 at 11:30 AM, the Director of Nurses (DON) revealed we have done multiple in-services regarding hand washing. Our expectation is that while administering medications, proper hand hygiene is utilized, which is a vital part of ensuring that we possibly prevent the spread of infections. During a subsequent interview on 6/30/25 at 12:10 PM, the DON stated, It is basic 101 nursing that when doing wound care treatment, you change out your gloves between removing your dirty dressings and cleaning and applying clean bandages. She revealed that not doing proper hand hygiene can aid in the possible spread of a wound infection, and there is no excuse for it. Record review of Resident #36's admission Record revealed the facility admitted the resident on 5/8/24 with diagnoses including Chronic Kidney Disease, Stage 4, and Dementia.