STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	07CC	A. BUILDING: _____ B. WING _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST NURSING HOME-CALHOUN, INC	152 BURKE CALHOUN CITY ROAD CALHOUN CITY, MS 38916

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 10/24/23-10/26/23. During the survey, the SA determined that the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm at M500 and M610. The census at the time of the survey was 95 and the facility is licensed for 120.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his	M 500		12/6/23

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M 500	Continued From page 1	M 500		

medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;

4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;

5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the

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M 500	Continued From page 2	M 500		

facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail

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M 500	Continued From page 3 unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on staff and resident interview, record review and facility policy review the facility failed to follow up and resolve grievances regarding residents' complaints related to cold food for two (2) of six (6) resident's present during the resident	M 500	**Corrective actions accomplished for residents found to have been affected by the deficient practice: Administrator, Director of Nursing and Social held a Resident Council meeting on	

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M 500	Continued From page 4 council meeting, Residents #15, and Resident #45, and failed to provide the residents with a way to file a grievance for six (6) of six (6) residents present during the resident council meeting. Residents # 6, Resident #15, Resident #44, Resident #45, Resident #49, and Resident #71. Findings include: Review of the facility policy titled, "Patient Complaint and Grievance Policy" with a revision date of 01/19 revealed, "Policy ... Patients and/or representatives have the right to voice concerns verbally or in writing when their expectations are not met ...Open communication with patients, visitors, providers, and employees is reinforced with a defined process that includes intake, routing/tracking, investigation, resolution and reporting of patient or patients representative's concerns. Patients and their representatives must be informed of the grievance/complaint process, including who to contact and how to express concerns ...III. Procedure for addressing and resolving Complaints and Grievances ...G. A complaint or grievance is considered resolved when the patient or representative is satisfied with the actions taken on his/her behalf ...The patient or representative is contacted and given the resolutions/actions..." Review of the facility Grievance Log revealed there were no documented grievances since 2015. An interview on 10/25/23 at 8:40 AM, with the Licensed Social Worker (LSW) revealed she has just been handling any issues or grievances as things are brought to her, but not documenting them. She stated that she really hasn't had any	M 500	November 1, 2023 to provide information necessary to voice a complaint or grievance with Resident #6, Resident #15, Resident # 44, Resident # 45, Resident #49 and Resident #71. Resident #15 and #45 were instructed during this meeting to notify staff immediately if food is cold so that it can be replaced. ** Identification of other residents having the potential to be affected by the same deficient practice: All resident who are admitted and presently reside at this facility have the potential to be affected by the deficient practice of failing to follow-up and resolve grievances regarding residents' complaints. **Measures put into place or systemic changes to ensure the deficient practice will not recur: Policy entitled Resident Complaint and Grievance was reviewed by Administrator, Director of Nursing, Quality Control Nurse and Social Worker with revisions made on October 30, 2023 to include the procedure for addressing and resolving complaints and grievances, time frame and documentation. Staff were in-serviced on the revised policy on 11-1-2023, 11-3-2023 and 11-6-2023 Policy signage entitled, "How to Report a Complaint or Grievance" was created and posted at three location in the facility by the Administrator. The north unit, south unit and front entrance now has signage with instructions for filing a voiced or	

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M 500	Continued From page 5 issues or grievances come up. She confirmed that she has had several complaints about cold food but does not document what she has done to fix it or if the residents felt like the issue was resolved. When asked what the purpose of a grievance log was, the LSW responded "that's a good question". An interview on 10/25/23 at 8:55 AM, with the Administrator confirmed that they have not been documenting grievances. She stated that the facility has had some grievances that should have been documented and followed up on. She stated that "it is just like nursing 101, if it is not documented then it wasn't done." She stated the purpose of a grievance log is to monitor and follow up on the grievance to document it has been resolved and we should have a way for the residents to voice a grievance. During the Resident Council Meeting on 10/25/23 at 11:14 AM, the 6 residents that were present revealed they were not aware of how to file a grievance or if the facility had a grievance officer that handles grievances. During the resident council meeting Resident #15 and Resident #45 stated that the food is sometimes cold, and Resident #45 revealed he has complained about that a lot to the kitchen staff and in the Resident Council meetings. Resident #45 revealed no one has ever come to him to tell him what they have done to fix the issue or ask if he felt like it had been resolved. He stated that he had been complaining about the food being cold for a while now but "feels like the left hand doesn't know what the right hand is doing, and it hasn't seemed to get much better." An interview on 10/25/23 at 2:00 PM, with the Administrator confirmed that they should have	M 500	written complaint. A Resident Council meeting was held on November 1, 2023 with both verbal and written explanation for filing a complaint or grievance given to all residents in attendance. A copy of the procedure for filing a complaint has been mailed to the responsible party of all residents that reside in our facility. A complaint and grievance log will be monitored through our Occurrences, Safety, Claims, Accreditation and Regulatory (OSCAR) reporting system utilized by the Baptist Health Care System. Utilization of the OSCAR system was put into effect on October 30, 2023. **Facility plan to monitor its performance to make sure the solutions are sustained: The corrective action will be monitored by the Quality Assurance(QA) Coordinator completing a verification weekly on Wednesday during the Interdisciplinary care plan meeting. This verification was implemented by the Administrator on November 1, 2023 and will remain a permanent part of our Wednesday Interdisciplinary care plan meeting. The QA Coordinator will monitor this verification form monthly. This Quality Assurance and Performance form has been implemented and will be reviewed on 12-6-2023. This deficiency, the corrective action an any further problems noted will be presented to the QA Committee monthly for five months for review and	

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M 500	Continued From page 6 been documenting grievances, what was done to resolve it and if it was resolved according to the resident and reporting that information back to the residents. Record review of Resident #6's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/20/23 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 13 which indicated the resident is cognitively intact. Record review of Resident #15's MDS with an ARD of 09/18/23 revealed under Section C a BIMS score of 15, which indicated the resident is cognitively intact. Record review of Resident #44's MDS with an ARD of 10/09/23 revealed under Section C a BIMS score of 15, which indicated the resident is cognitively intact. Record review of Resident #45's MDS with an ARD of 10/11/23 revealed under Section C a BIMS score of 12, which indicated the resident is cognitively intact. Record review of Resident #49's MDS with an ARD of 09/27/23 revealed under Section C a BIMS score of 05, which indicated the resident is severely cognitively impaired. Record review of Resident #71's MDS with an ARD of 09/07/23 revealed under Section C a BIMS score of 15, which indicated the resident is cognitively intact.	M 500	recommendation as needed.	
M 610	45.21.2 Activities of daily living	M 610		12/6/23

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M 610	Continued From page 7 Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observations, staff interview, record review and facility policy review the facility failed to get a resident up in her wheelchair for all meals; for a resident that required assistance with their Activities of Daily Living (ADL) for one (1) of 20 resident's reviewed for ADLs. Resident #70 Findings include: Review of the facility policy titled, "Activities of Daily Living" with the last review date of 4/3/18 revealed "Policy ... (Proper name of the facility) will provide assistance to residents as necessary and supervise and assess resident function in order to plan care to maintain optimum ADL function as long as possible ..." An observation on 10/24/23 at 9:30 AM, revealed that Resident #70 was lying in bed and had confused responses to an attempted interview. An observation on 10/24/23 at 11:45 AM, revealed Resident #70 was lying in bed and had no response to an attempted interview.	M 610	** Corrective actions accomplished for resident #70 found to have been affected by the deficient practice: Resident #70 was transferred by lift to her chair and up for the breakfast meal on 10-27-2024. ** Identification of other residents having the potential to be affected by the deficient practice: All residents who are admitted and presently reside at this facility have the potential to be affected by the deficient practice of failing to provide Activities of Daily Living (ADL)Assistance. **Measures put into place to prevent or systemic changes to ensure the deficient practice will not recur: DON provided in-service educating all Certified Nurse Aides (CNA) regarding ADL assistance for dependent residents on November 1, November 3, and	

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M 610	Continued From page 8 An observation and interview on 10/25/23 at 8:30 AM, revealed Resident #70 was lying in bed. Interview on 10/25/23 at 12:10 PM, with Certified Nurse Assistant (CNA) #2 revealed she is the CNA for this resident. She confirmed that the resident cannot get herself out of bed and that staff must use a lift. She confirmed that the resident had not been up today. Interview on 10/25/23 at 4:00 PM, with the Director of Nurses (DON) confirmed that it was documented that the resident had not been gotten up for all meals over the last 7 days even though it was care planned to do so. She stated sometimes the resident refuses, but there is no documentation that the resident had refused. Record review of Resident #70's "Completed Care Task" 10/18/23 - 10/25/23 revealed that there were six (6) meals over the last seven (7) days that the resident remained in bed and was not gotten up to a chair to eat her meal. Review of the Resident #70's October 2023 Electronic Treatment Administration Record (ETAR) revealed no behavior indicated for the last 7 days that would have prevented the staff from getting her out of the bed to a chair for meals. Record review of Resident #70's "Face Sheet" revealed the resident was admitted to the facility on 01/15/21 with medical diagnoses that included Unspecified Dementia, unspecified severity with other behavioral disturbances. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of	M 610	November 6, 2024. Effective November 7, 2023 all CNA's are required to review and sign care plans weekly to ensure knowledge of ADL changes. Licensed Practical Nurse will complete ADL-Staff Assistance monitoring form each shift. **Facility plan to monitor its performance to make sure solutions are sustained: The corrective action will be monitored by the QA nurse completing ADL-Staff Assistance Audit form weekly. This audit will contain a review of ten percent of the facility residents picked at random. Effective 11-6-2023 the audit will be completed weekly for three months and will be presented at the QA Committee monthly meeting. Effective November 6, 2023 Licensed Practical Nurse will complete weekly for three months ADL-Staff Assistance monitoring form on 10% of assigned hallway each shift. This QA form was implemented by the Administrator on November 6, 2023 and will be evaluated for effectiveness at the QA meeting to be held on December 6, 2023. This deficiency, the corrective action and any further problems noted will be presented to the QA Committee monthly for three months with review and recommendations as needed.	

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M 610	Continued From page 9 08/16/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 99, which indicated the resident is severely cognitively impaired and in Section G that the resident is totally dependent and requires two-person assistance for transfers.	M 610		