MSDH - Health Facilities Licensure and Certification

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 _____	C 05/05/2025

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 and Complaint Investigations (CI) MS#27884, CI MS#27886, and CI MS#28744 at the facility from 04/29/25 through 05/05/25. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. The facility was found not to be in compliance with CI MS#28744 related to sexual abuse when facility failed to prevent sexual abuse of Resident #56, who was a vulnerable adult, when they allowed Resident #16, who was a known risk for sexual behaviors towards others, to enter her room and sexually assault Resident #56 while she lay in her bed. The SA cited M500 at Level IV Immediate Jeopardy (IJ). The facility was found not to be in compliance regarding CI MS#27884 and cited M640 and M1570. CI MS#27886 was investigated with no deficiencies cited. Additional regulatory deficiencies were cited at M610 and M815. The facility's failure to prevent sexual abuse resulted in Resident #56 being found on 04/24/25 at approximately 3:00 PM, by a Certified Nursing Assistant (CNA) with Resident #16 in the bed and on top of her, with his hand inside her incontinence brief, performing jabbing motions. Resident #16 became violent with the staff when they tried to remove him from Resident #16's room where he hit a staff member with his fist. Resident #16 had a history of sexual behaviors towards staff that started on 11/05/24 and the facility did not prevent further sexual behaviors that put all the residents at risk. This situation placed Resident #56 and other residents at risk for sexual assault in a situation that caused and was likely to cause serious	M 000		

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M 000	Continued From page 1 injury, serious harm, serious impairment, or death. During the investigation of CI MS#28744, the SA identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which existed at Rule 45.17.2 Resident Rights (M500) and began on 11/05/24, when Resident #16 began to exhibit sexual behaviors towards staff. The SA notified the facility's Administrator of the IJ and SQC on 04/30/25 at 1:20 PM. The facility submitted an acceptable Removal Plan on 05/02/25, in which they alleged all corrective actions to remove the IJ and SQC were completed on 05/01/25, and the IJ was removed on 05/02/25. The SA validated the Removal Plan on 05/05/25 and determined the IJ and SQC was removed on 05/02/25, prior to exit. Therefore, the scope and severity for Rule 45.17.2 Resident Rights (M500) was lowered from a scope and severity of Level IV to a Level II while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. At the time of the survey, the facility was licensed for 120 beds and had a census of 95 at the time of the survey.	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:	M 500		5/29/25

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M 500	Continued From page 2 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 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	M 500		

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M 500	Continued From page 3	M 500		

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 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;

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M 500	Continued From page 4 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 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	M 500		

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M 500	Continued From page 5 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 IV Based on staff interviews, record review and facility policy review, the facility failed to protect the resident's right to be free from sexual abuse for one (1) of 20 residents on the Special Care Unit. Resident #56. Resident #56 was found on 4/24/25 at approximately 3:00 PM, by a Certified Nursing Assistant (CNA) with Resident #16 in the bed and on top of her, with his hand inside her incontinence brief, performing jabbing motions. Resident #16 became violent with the staff when they tried to remove him from Resident #16's room where he hit a staff member with his fist. The facility's failure to prevent the sexual abuse of Resident #56 placed Resident #56 and other residents at risk for sexual assault, in a situation that caused and was likely to cause serious injury, serious harm, serious impairment, or	M 500	**Corrective actions accomplished for resident found to have been affected by the deficient practice: Resident #56's care plan was immediately reviewed on 4/25/25 and revised by the interdisciplinary team to reflect current needs and appropriate interventions. The resident was closely monitored starting on 4/24/25, and protective measures were put in place to ensure safety and well-being. Resident #16 was transferred to an inpatient geropsychiatric unit at the order of his attending physician for possible adjustments of his medications on 4/25/25. The behavior was disclosed to his son. **Identifications of other residents having the potential to be affected by the same	

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M 500	Continued From page 6 death. This situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 11/05/24 when Resident #16 began to exhibit sexual behaviors towards staff and the facility did not implement interventions to prevent further sexual behaviors. The SA notified the facility's Administrator of the IJ and SQC on 4/30/25 at 1:20 PM and provided the Administrator with the IJ templates. The facility submitted an acceptable Removal Plan on 5/02/25, in which they alleged all corrective actions to remove the IJ and SQC were completed on 5/1/25, and the IJ removed on 5/2/25. The SA validated the Removal Plan on 5/05/25 and determined the IJ and SQC was removed on 5/2/25, prior to exit. Therefore, the scope and severity for Rule 45.17.2 (M500) was lowered from a scope and severity of Level IV to Level II while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: Record review of the facility policy "Abuse and or Suspected Crimes Reporting Under the Elder Justice Act", last reviewed 3/24 revealed, " ...Sexual abuse includes ...sexual assault ... It is the policy of [Proper Name of Facility] that all residents will be free from physical, mental, and/or verbal abuse..." Record review of the facility investigation	M 500	deficient practice: A body audit of all residents was completed by Interim Director of Nursing and Assistant Director of Nursing to verify no similar injuries on 4/28/25. A comprehensive review of all residents care plans and recent incident reports was conducted by Care Plan Nurse and Minimum Data Set Nurse to identify any similar gaps in reporting or care planning on 4/28/25. No additional residents were found to be directly affected, but all care plans were reviewed and revised as needed by the interdisciplinary team. **Measures put into place or systemic changes to ensure the deficient practice will not recur: Mandatory abuse prevention and reporting training was completed on 5/5/25 by Staff Development Specialist for all staff prior to returning to work. A facility-specific Abuse Reporting Tip Sheet was developed and posted at all nurse stations on 4/30/25. All resident care plans were immediately reviewed and revised by Care Plan Nurse and Minimum Data Set Nurse on 4/28/25. Identified behavioral issues of any resident will be immediately addressed and brought to the Care Plan meeting on the next weekly meeting on 5/7/25.	

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M 500	Continued From page 7 revealed that on 4/24/25 at approximately 3:00 PM, a Certified Nursing Assistant (CNA) was walking down the hall and saw Resident #16 on top of Resident #56 in an inappropriate manner. Both residents were clothed. The CNA called for assistance from other staff to remove Resident #16 from Resident #56's bed. Upon assessment by the Registered Nurse (RN), Resident #56 was noted to have scratches on her upper legs and scratches and bruising on her labia. The CNA reported that Resident #16's hand was down inside Resident #56's diaper, and he was making a jabbing motion with his hand. Record review of the "Default Flowsheet Data" for Resident #56, under "Genitourinary" on 4/24/25 at 4:13 PM, documented scratches, skin discoloration, and slight edema noted to the labia; maroon/purple and pale overall paleness; maroon/purple bruising noted to the left thigh; maroon/purple bruising with yellow outer edges noted to the left lateral eyebrow; and scratches noted to the left thigh and bilateral outer labia with bruising and redness to both areas. Record review of the "Nursing Note" for Resident #56, dated 4/29/25, written by Licensed Practical Nurse (LPN) #2 revealed a late entry for 4/24/25 that stated, "This nurse alerted by CNA to come to elder's room. When this nurse entered room, observed a male elder on top of this female elder, both were fully clothed, male elder refuses to get off of female elder and required 2 (two) more CNA to assist, male elder becomes violent and punches one of the CNAs in the nose, male elder removed from this elder's room and taken back to his room with supervision. [Proper Name of Administrator] aware ... Social Worker (SW) aware and she talked to family, and [Proper Name of Physicians] aware per this nurse ..."	M 500	**Facility's plan to monitor its performance to make sure that solutions are sustained: Five monthly staff interviews will be conducted by the Staff Development Specialist to assess staff knowledge and competence regarding abuse recognition, reporting procedures, and interdisciplinary care planning on 5/22/25. Interviews will be documented and reviewed in monthly Quality Assurance Performance Improvement meetings. The interdisciplinary care plan team will conduct monthly reviews of resident care plans for accuracy, timely updates, and proper documentation of abuse risk factors and interventions on 5/7/25. Audits of all abuse allegations and resident care plans are performed for a minimum of six months starting on 4/25/25. These audits will be conducted by Assistant Director of Nursing and the Care Plan Nurse. Audit results will be tracked using a standardized tool and presented during Quality Assurance Performance Improvement starting on 5/29/25 and monthly for six months. Ongoing Quality Assurance Performance Improvement review of audit results will be monthly for six months starting on 5/29/25 for six months and retraining initiated if gaps are identified.	

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M 500	Continued From page 8 Record review of the "Nursing Note" for Resident #16, dated 4/24/25, documented that a CNA doing a visual check observed the elder in a female elder's room on top of her. The clothes were intact. When attempts were made to remove this elder, he became violent and punched a CNA in the nose. He was returned to his room, and supervision was provided at his doorway to maintain the female resident's safety. In an interview with CNA #3 on 4/29/25 at 10:45 AM, she stated that on the afternoon of 4/24/25, she came out of another resident's room and heard a commotion. She saw staff going into Resident #56's room, so she followed and saw Resident #16 lying on top of Resident #56. Both residents were fully dressed, and Resident #16 had his hand up Resident #56's pants leg. She said staff were attempting to remove him and he became agitated, hitting a CNA in the face. She stated it took about four staff members to remove him. CNA #3 further stated that Resident #16 frequently makes inappropriate statements about wanting sex and has grabbed CNAs between their legs, but she had never seen him attempt to touch another resident in this way. She said CNAs usually take two people when giving him care and try to discourage his behavior, but that he still grabs staff between their legs. After the incident, he was taken to his room, and the CNAs on duty conducted visual checks, but he was not on 1:1 supervision. At some point, he came out of his room and was in the dining area making sexual statements in front of other residents, so they returned him to his room. In an interview with the Administrator on 4/29/25 at 12:50 PM, he stated that on 4/24/25 at approximately 3:20 PM, he was notified by LPN	M 500		

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M 500	Continued From page 9 #2 that Resident #16 was found on top of Resident #56, and he called for a Registered Nurse (RN) to assess her. He stated that at that time he was not informed that Resident #16 had his hands in Resident #56's brief. He stated that the resident's responsible party was notified by the Social Worker, and the physician was also notified. He verified that he reported the incident online to the Attorney General's Office. The Administrator stated that staff working the unit were instructed to supervise Resident #16 until he was transferred to the geriatric hospital on the afternoon of 4/25/25. He verified that no other residents were assessed for signs of abuse at that time and no other body audits were performed. The Administrator confirmed that this is a memory care unit that both Resident #56 and Resident #16 reside on. In an interview with RN #3 on 4/30/25 at 9:15 AM, she stated that on 4/24/25 around 4:00 PM, she was called to assess Resident #56 after Resident #16 was found on top of her. Resident #56 was noted to have irregularly shaped scratches and bruising on her left thigh, approximately the size of a quarter, bruising to her left eye, and scratches and bruising on both sides of her labia. She stated she notified the Administrator and Social Worker of her finding in the body audit. In an interview with CNA #6, #7, and #8 on 4/30/25 at 10:00 AM, they all stated that Resident #16 has a history of touching and grabbing staff's private parts and making comments like "give me that p****" in front of other residents. They stated they had never seen him attempt to touch other residents, but he does touch staff and that he makes inappropriate sexual comments to other residents. They said that after the incident on 04/24/25, while Resident #16 was in the dining	M 500		

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area on 4/25/25, he was fondling himself, making sexual gestures at female residents, and making inappropriate sexual statements, after which he was returned to his room.

In an interview with LPN #3 on 4/30/25 at 10:15 AM she stated that Resident #16 has always exhibited aggressive verbal sexual behaviors. He makes sexual gestures toward anyone who walks by and says things like "I want your p****." She stated he grabs CNAs during Activity of Daily Living (ADL) care and masturbates in common areas. She said that on the morning of 4/25/25, she was instructed to keep him under supervision in the dining room, but he continued to display inappropriate sexual behaviors. Although he was returned to his room, he is ambulatory and would come right back out. She added that he wanders and walks around the unit and, if his roommate is in the bathroom, he will go into other resident's room to use the restroom.

In a telephone interview with CNA #2 on 4/30/25 at 2:00 PM, she confirmed that on the afternoon of 4/24/25, she was returning from filling the ice cart and saw Resident #16 on top of Resident #56 with his hand under her pants, fondling her forcefully. She stated that she witnessed Resident #56 lying on her back with her hands shaking and held over her head and face, while Resident #16 held her down forcefully with his left arm. CNA #2 yelled for help, and three other CNAs came. They physically removed Resident #16, who was aggressive, agitated, and combative, hitting and kicking at staff. She stated he hit her, CNA #3, in the face with his fist. After much effort, the staff removed him from Resident #56's bed and returned him to his room for supervision. She described him as violent and said he has always made sexual statements and

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M 500	Continued From page 11 grabbed staff. In a telephone interview with LPN #2 on 4/30/25 around 2:30 PM, she stated she was called to Resident #56's room on the afternoon of 4/24/25 and witnessed Resident #16 on top of Resident #56. Both were clothed, and she did not see his hand in her brief. She confirmed Resident #16 had a history of inappropriate sexual verbalizations, but she had not seen him touch other residents. She verified she notified the Administrator. In a telephone interview with the Psychiatric Nurse Practitioner (NP) on 5/1/25 at 10:15 AM, she stated that the staff keep her updated on Resident #16's behaviors and notify her if he has any increases. She verified that Resident #16 had inappropriate sexual behaviors and had an increase of these behaviors in November of last year and at that time his Depakote was increased on 11/4/25. During a further record review of the medical record for Resident#16 the notes below were revealed: Record review of "Nursing Note" for Resident #16 dated 11/5/24 revealed "elder has inappropriate behaviors of groping at staff ...sexually inappropriate behaviors, regularly touch his genitalia in public..." Record review of "Psychiatric Progress Note "and "Case Conceptualization" note for Resident #16 dated 11/7/24 completed by Nurse Practitioner, revealed a diagnosis of Dementia. Review of the "Case Conceptualization" note revealed "His Depakote was recently increased due to increase in inappropriate behaviors"	M 500		

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M 500	Continued From page 12 Record review of "Psychiatric Progress Noted" for Resident #16 dated 1/9/25 completed by Nurse Practitioner, revealed "Staff reports that patient continues to exhibit inappropriate sexual behaviors ..." Record review of "Social Work" note, for Resident #16 dated 2/3/25 revealed "Elder made eye contact with the Social Worker and made sexual statements during the interview...According to staff, the resident makes inappropriate sexual comments to staff routinely ..." Record review of "Progress Notes", for Resident #16 dated 2/12/25, and signed by the PTA revealed "Pt (patient) stated, 'I'll go for a walk with you if you give me some sugar' Then patient attempted to use his foot to inappropriately touch Licensed Physical Therapy Assistant (LPTA) where he stated "give me some p**** ..." Record review of "Progress Notes", for Resident #16 dated 2/17/25, and signed by the Physical Therapy Assistant (PTA) revealed " Attempted Physical Therapy Treatment where patient was very inappropriate where he kept attempting to inappropriately touch Licensed Physical Therapy Assistant (LPTA) ...patient kept attempting to inappropriately touch LPTA while saying very inappropriate stuff. LPTA discontinued treatment. Nursing staff notified." Record review of "Nurses Notes", for Resident #16 dated 2/20/25 revealed " ...elder stuck his foot between CNA's legs in a sexual manner..." Record review of the "Nursing Note" for Resident #16, dated 4/25/25, revealed that the elder ambulated off the unit with staff times two for	M 500		

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M 500	Continued From page 13	M 500		

transfer to [Proper Name of Facility].

Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/3/25 for Resident #16 revealed a Brief Interview for Mental Status Score (BIMS) score of 3 indicating severe cognitive impairment.

Record review of "Psychiatric Progress Note" for Resident #16 revealed a diagnosis of Dementia and he was admitted to the facility on 09/23/22.

Record review of the MDS with an ARD of 2/13/25 for Resident #56 revealed a BIMS score of 7 indicating severe cognitive impairment.

Record review of the demographic page for Resident #56 revealed that the facility admitted her on 4/15/21 with diagnosis to include Alzheimer's Disease.

Review of the removal plan revealed that the facility took the following actions:

Immediate Action started on 4/24/2025 at approximately 2:53 PM:
1. On 04/24/2025 at 2:53 PM, Certified Nursing Assistant (CNA) 1 saw Resident #16 on top of Resident #56. CNA 1 yelled for help. Licensed Practical Nurse (LPN) 1 and CNA 1, CNA 2, and CNA 3 entered the room and removed Resident #16 and took him back to his room where supervision was provided by CNA 2.

2. On 04/24/2025 at 3:05 PM, Licensed Master Social Worker (LMSW) and Nursing Home Administrator (NHA) notified by LPN of the incident.

3. On 4/24/2025 at 3:06 PM, a CNA was stationed

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M 500	Continued From page 14 outside the door of Resident #16 until transportation arrived to take him to an inpatient geropsychiatric unit. 4. On 4/24/2025 at 3:50 PM, LMSW went to evaluate Resident #16 for mood or behavior changes, and none were noted. 5. On 04/24/2025 at 4:13 PM, Staff Development Specialist (SDS) performed a full body audit on Resident # 56. The findings included red purple bruising with yellow edges noted to left outer eyebrow, scratches, skin discoloration and slight edema noted to exterior labia overall paleness maroon/purple bruising noted to left thigh approximate size of a quarter scratches noted to left thigh and bilateral outer labia with bruising and redness noted to both areas. 6. On 04/24/2025 at 4:21 PM, Nursing Home Medical Staff Director (NHMSD) notified by phone by RN 1 of findings from body audit. No orders received. 7. On 04/24/2025 at 4:28 PM, NHA notified the Ombudsman of the incident. 8. On 04/24/2025 at 5:49 PM, the LMSW notified Resident #56's Responsible Party (RP) of the incident. 9. On 04/24/2025 at 5:54 PM, NHA and Risk Manager (RM) notified the Director of Risk Management (DRM) of the event. to discuss the event and necessary actions steps needed to be implemented immediately to prevent any further harm. The recommended actions included continuing to seek inpatient geropsychiatric unit placement for Resident # 16 and continuing supervision.	M 500		

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M 500	Continued From page 15 10. On 04/24/2025 at 6:00 PM, RP of Resident # 16 was notified by LMSW regarding the incident and an order for inpatient geriatric psych placement. 11. On 04/24/2025 at 7:00 PM, LMSW verified that a CNA was placed outside Resident #16's room. 12. On 4/25/2025 at 11:23 AM, NHA notified the Mississippi State Department of Health (MSDH) of the incident by telephone. 13. On 04/25/2025 at 12:19 PM a follow-up weekly body audit completed on Resident # 56. No additional injuries identified. 14. On 04/25/2025 at 1:32 PM, Primary physician notified of Resident # 16 acceptance at behavioral health facility. 15. On 04/25/2025 at 3:46 PM, NHA notified the Attorney General's Office of the incident. 16. On 04/25/2025 at 3:53 PM, NHA sent an email reporting the incident to the MSDH via email to facilityreportedincidents@msdh.ms.gov. 17. On 04/25/2025 at 4:16 PM, Resident # 16 was transferred to a behavioral health facility. 18. On 04/30/2025 at 8:30 AM, NHA notified local law enforcement of the incident. 19. On 04/30/2025 at 3:30 PM, local law enforcement on-site. 20. On 04/30/2025 at 4:48 PM, Incident report received from local law enforcement.	M 500		

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M 500	Continued From page 16 21. On 4/30/2025 at 5:00 PM, the Director of Risk Management in-serviced the NHA and the Interim Director of Nursing (IDON) on timely reporting of suspected abuse. 22. On 4/30/2025 at 6:00 PM, the Interim Director of Nursing and SDS initiated Abuse training to include types of abuse, prevention and employee responsibilities for reporting suspected abuse for all 129 employees. No staff will be allowed to work until in serviced. 23. On 4/30/2025 at 6:00 PM, the IDON and SDS initiated an in-service for all Nursing Staff on implementing and developing Comprehensive Care Plans to include interventions that address inappropriate sexual behaviors. No staff will be allowed to work until in serviced. 24. No staff, including the Director of Nursing, will be allowed to work until in serviced. 25. On 4/30/2025 at 7:30 PM, an Ad hoc Quality Assurance (QA) meeting was held to review the immediate jeopardy related to F 600 Free from Abuse and Neglect, F 609 Reporting of Alleged Violations, and F 656 Develop/Implement Comprehensive Care Plan and conducted a Root Cause Analysis (RCA) and review policy and procedures for changes. Attendees were the NHA, NHMSD, interim-Director of Nursing (DON), Infection Control Nurse Manager (ICNM), and RM. 26. On 5/1/2025 at 3:29 PM, a Follow-up Ad hoc Quality Assurance (QA) meeting was held to review the immediate jeopardy related to F 600 Free from Abuse and Neglect, F 609 Reporting of	M 500		

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M 500	Continued From page 17 Alleged Violations, and F 656 Develop/Implement Comprehensive Care Plan and conducted a Root Cause Analysis (RCA) and review policy and procedures for changes. Attendees were the NHA, NHMSD, DON, ICNM, RM, Human Resources Manager (HRM), and RN 1. 27. On 5/1/2025 at 5:30 PM, the Minimum Data Set Nurse (MDSN) completed a 100% care plan audit for behaviors for all 95 residents to include residents at risk for sexual behaviors. Findings of the audit revealed that no other residents had inappropriate sexual behaviors. Facility alleged Immediate Jeopardy was removed as of 5/2/25. Validation: The State Agency (SA) validation of the Removal Plan was made during an on-site survey through record review and interviews on 5/5/25. The SA determined all corrective actions were completed on 5/1/25 by the facility and the IJ was removed on 5/2/25.	M 500		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level III	M 640	**Corrective actions accomplished for resident found to have been affected by	5/29/25

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M 640	Continued From page 18 Based on staff interview, record review, and facility policy review the facility failed to ensure a resident was free from accident hazards when the facility failed to ensure staff transferred the resident with the proper assistive devices for one (1) of three (3) residents reviewed for accidents. Resident #5. Findings Include: Record review of the facility policy "Falls Management" revealed "It is the goal of [Proper Name of Facility] to assure that our residents remain free of accident hazards as possible and that each resident receives adequate supervision and assistive devices as needed to prevent accidents." Record review of the facility investigation revealed that on 1/27/25 at approximately 1:35 PM Resident #5 was being assisted from her bed to the wheelchair by two (2) Certified Nursing Assistants (CNA), her legs got weak, and the CNAs assisted her to the floor. She was assisted from the floor without difficulty and the Registered Nurse (RN) assessment revealed no injuries. On 1/28/25 at approximately 4:00 PM, Resident #5 complained of pain to her right leg, the physician was notified, and orders were obtained for a radiographic study. The resident was noted to have bruising and edema to her right leg. Her Responsible Party was notified of the findings, and the resident was transferred to the hospital. Evaluation at the hospital revealed that she had a right tibial plateau fracture. Record review of the Resident #5's "History and Physical", dated 1/28/25 for Resident #5 revealed "the patient arrived to the hospital after a fall at her nursing home a couple of days ago. She	M 640	the deficient practice: Resident #5's incident was reviewed on 1/28/25, and appropriate care plan updates were reviewed. Resident #5 was accessed by Registered Nurse and transferred to hospital on 1/28/25. Director of Nursing performed one on one in-service on safe transfers and following care plan with staff involved on 1/29/25. **Identifications 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 failure to follow the comprehensive care plan. **Measures put into place or systemic changes to ensure the deficient practice will not recur: Education on 5/16/25 by the Staff Development specialist provided to all nursing staff regarding comprehensive care plan. All residents care plans have been reviewed and updated by the Care Plan Nurse in last three months. All nursing staff will be required to sign care plan status sheet weekly to ensure knowledge of any changes made to care plan on 4/30/25. **Facility's plan to monitor its performance	

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M 640	Continued From page 19 states that she twisted he right knee under her when she fell and had pain. It has continued to swell and have ecchymosis. She finally presented for evaluation today and was found to have a right tibial plateau fracture. She is being admitted for orthopedic evaluation and surgical consideration ..." Record review of a "Nursing Note" dated 1/29/25 10:01 AM revealed a late entry for 1/27/25 at 1:35 PM indicating that Resident was lowered to the floor during a transfer when her knees became weak. No injuries were noted, and the resident had no complaints. There was no indication that the Residents responsible party was notified of the incident. Record review of the "Encounter Problems (Active) for Resident #5 revealed "Problem: Activities of Daily Living (ADLs) (Certified Nursing Assistant Care Plan)" revealed "I need assistance with my ADLs because of impaired vision, frequent bladder and bowel incontinence, generalized weakness, falls with right hip fracture ..." Under intervention description " Transfers: Extensive assistance two (2) care partners (using rolling walker). In an interview with CNA #5 on 4/30/25 at 9:00 AM, she stated that she and CNA #4 were assigned to take care of Resident #5 on 1/27/25. She stated that CNA #5 instructed her that they were going to transfer Resident #5 to the wheelchair because she was supposed to transfer to another room. She stated that she had never transferred Resident #5 before, and CNA #5 instructed her to get beside the resident and stand her up by placing her arm under the resident's arm and lifting. She stated that she questioned CNA #5 on the technique because	M 640	to make sure that solutions are sustained: The corrective action will be monitored by the Quality Assurance nurse completing "Care Plan Review Audit" weekly on 5/21/25 for four months and monthly for six months. This audit will contain a review of ten percent of the facility residents by the Restorative Nurse directly observing residents transfer to ensure performed correctly. The audits results will be presented to the Quality Assurance Performance Improvement Committee starting on 5/29/25 and monthly for six months with review and recommendations as needed.	

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M 640	Continued From page 20	M 640		

she had never transferred a resident in this way and did not think it was correct, but that CNA #5 instructed her that that was the way to transfer this resident. She stated they stood the resident, but she was not able to bear weight and CNA #5 told her to lower the resident to the floor. She stated as they were lowering the resident her right leg went up underneath her. She stated that she does not recall exactly how the resident was positioned or if the resident complained because she left the room when the resident was put back in the chair because she was upset that the resident had to be lowered to the ground, because she did not feel she had a good hold on the resident during the transfer due to her position beside the resident. She verified that they did not use a rolling walker. She stated that she had not checked the care plan to determine how the resident transferred because CNA #5 had transferred her before.

Telephone interview with CNA #5 on 5/2/25 at 12:00 PM, she stated that on 1/27/25 she and CNA #4 went in to assist Resident #5 to the wheelchair to transport her to another room. She stated that she told CNA #4 to get on one side, and she would get on the other and assist the resident to the wheelchair. She stated during the transfer Resident #5 was unable to bear weight on her legs and they had to lower to the floor. She stated that she did not notice Resident #5's leg going under her while they were lowering her to the floor. She stated that she called the nurse who came in to check the resident. CNA #5 stated that she always transferred Resident #5 this way and had no problems. She stated she felt like CAN #4 did not have a good hold on the resident during the transfer. CNA #5 admitted that she did not use a walker when transferring the resident, stating that she had never used a

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M 640	Continued From page 21 walker when transferring the resident. CNA #5 further stated that she did not check the residents care plan to see how she was supposed to transfer but agreed that had she used the walker it is likely that the resident could have used it to help bear weight and would not have had to be lowered to the ground. Interview with the Administrator (ADM) on 5/1/25 at 8:15 AM, he stated that he was not the ADM when the incident occurred with Resident #5, but that he had since spoken to the resident's Resident Representative (RR). He further stated that he explained to the RR that the cause of the fracture was not due to the RN not notifying him, but that it was caused by the CNAs not transferring the resident correctly. Record review of Resident #5's "Demographic Page" revealed the facility admitted the resident on 6/14/24.	M 640		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the	M1570		5/29/25

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M1570	Continued From page 22 program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Level II Based on observation, staff interview, and facility policy review the facility failed to put infection control measures in place to prevent the possible spread of infections for one (1) of 95 residents residing in the facility. Resident #81 Findings include: Record review of facility policy titled, "Contact Precautions" dated 2018, revealed, "It is the intent of this facility to use contact precautions for residents known or suspected to have serious illnesses easily transmitted by direct patient contact or by contact with items in the patient's environment. Contact Precautions shall be used in addition to Standard Precautions for residents with infections that can be easily transmitted by direct and indirect contact". Resident #81 An observation on 4/29/25 at 12:55 PM revealed an isolation cart outside of Resident #81's room. There was no signage to indicate the type of isolation or precautions to be used.	M1570	**Corrective actions accomplished for resident found to have been affected by the deficient practice: Contact isolation signage was immediately placed on Resident #81's door on 5/5/25. Infection Preventionist notified on 5/5/25. Resident care protocols were reviewed with assigned staff. **Identifications of other residents having the potential to be affected by the same deficient practice: All residents on any form of isolation precautions were reviewed to ensure signage posted per policy on 5/6/25 by Infection Preventionist. **Measures put into place or systemic changes to ensure the deficient practice will not recur: Nursing staff educated on the isolation policy and signage procedures. Completed on 5/22/25 by Staff	

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M1570	Continued From page 23 During an interview on 4/30/25 at 8:45 AM, Registered Nurse #1 revealed that Resident #81 was in contact isolation for a wound infection with MRSA (Methicillin-resistant Staphylococcus aureus). She confirmed there was no contact isolation signage for this resident to inform staff or visitors of what precautions were required for this specific isolation. During an interview on 4/30/25 at 8:50 AM, the Interim Director of Nursing (DON) confirmed that signage was necessary to indicate what type of isolation and what precautions were required to decrease the spread of infection. She admitted that the facility failed to provide signage to inform staff and visitors of the precautions that were needed. She stated that isolation signage was required for residents in isolation so that visitors and staff were informed of what type of precautions needed to be used. Record review of Resident #81's " Physician's Orders" revealed an order for "contact isolation status ... starting on Monday 2/24/25 ... Organism : MRSA (Methicillin-resistant Staphylococcus aureus); Source: Wound". Record review of Resident #81's "Demographic Sheet" revealed the facility admitted the resident on 1/4/24. Record review of Resident #81's "Problem List" revealed the resident had a diagnosis of Alzheimer's Disease, Vascular Dementia, and Pressure Injury of Buttock. Record review of Resident #81's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/27/25 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 5	M1570	Development Specialist. Nursing staff to round daily and confirm signage is present on 5/21/25. Add compliance to Quality Assurance Performance Improvement tracking and infection control audits. **Facilitys plan to monitor its performance to make sure that solutions are sustained: Rounding sheet updated to include isolation signage. Completed on 5/21/25. Audit results will be reviewed monthly in Quality Assurance Performance Improvement meeting starting on 5/29/25 for six months. Infection Preventionist will audit all isolation rooms Monday-Friday for two weeks, then weekly for three months starting on 5/21/25. Audit results will be reviewed monthly in Quality Assurance Performance Improvement meeting starting on 5/29/25 for six months. Any noncompliance will be immediately addressed with staff re-education and coaching.	

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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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M1570	Continued From page 24 which indicated the resident had severe cognitive impairment.	M1570		