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	25A233	A. BUILDING _____ B. WING _____	05/05/2025

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BAPTIST NURSING HOME-CALHOUN, INC	152 BURKE CALHOUN CITY ROAD CALHOUN CITY, MS 38916

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F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, record	F 565	**Corrective actions accomplished for	5/29/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/22/2025

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F 565	Continued From page 1 reviews, and facility policy review, the facility failed to promptly resolve grievances regarding cold food for four (4) of six (6) residents present in Resident Council. (Resident #34, # 37, #47, and #84) Findings Include: Review of facility policy titled, "Patient Complaint and Grievance Policy" effective date 3/18, last review date 1/22, revealed, "Policy: Providing quality services is the primary objective ...Feedback and comments received by patients or their representatives provide the organization with opportunities for improvement and enhancements of services. Patients and/or their representatives have the right to voice concerns verbally or in writing when their expectations are not met ..." During the Resident Council meeting held on 4/30/25 at 2:00 PM, Residents #34, #37, #47, and #84 expressed ongoing concerns regarding cold food, specifically highlighting that eggs served at breakfast were consistently cold. Resident #34 mentioned that she was often the last to receive her food tray and recalled that previously a "brick" was placed under the plate to keep it warm, but this practice has ceased. All residents agreed that they raised these food concerns in multiple Resident Council meetings over the past months, but no improvements have been made. Record review of the "Resident Council Minutes" dated 11/27/24, 2/28/25, and 3/26/25 revealed repeated documentation of complaints regarding cold food yet there was no evidence to track what the facility did to resolve the complaints.	F 565	residents found to have been affected by the deficient practice: Resident #34, #37. #47 and #84 were followed up with individually by Director of Nursing on 5/5/25 and reminded to notify staff immediately if issue with food. Temperature-checked trays were provided to confirm improvements on 5/5/25. **Identifications of other residents having the potential to be affected by the same 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 follow-up and resolve grievances regarding residents' complaints. Resident Council minutes from the past three months were reviewed for unresolved food-related complaints on 5/6/25. Grievance log audited by Risk Manager to ensure no other food complaints were missed on 5/6/25. **Measures put into place or systemic changes to ensure the deficient practice will not recur: Resident council leader was educated on 5/21/25 by Risk Manager about entering of grievances into OSCAR electronic platform.	

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F 565	Continued From page 2 An interview with the Activities Director (AD) #1 on 4/30/25 at 2:44 PM, she acknowledged that residents had previously communicated their dissatisfaction with cold food during Resident Council meetings. She revealed that after a Resident Council meeting, if a resident made a complaint, she made a copy of the minutes and gave it to the department to handle. She revealed that she never got anything back from the departments to know if the issues were resolved or ongoing. She confirmed the cold food complaints were not written up as a grievance and verbalized the issue was ongoing. The AD#1 admitted she was unaware of any specific actions taken by the dietary department in response to the food complaints. An interview with the Licensed Master Social Worker (LMSW) #1 on 4/30/25 at 2:55 PM, revealed that she was not aware of the food concerns and could only address issues if it was brought to her attention. An interview with the Dietary Manager (DM) on 5/01/25 at 10:40 AM revealed she was aware of the residents' complaints regarding cold food and had received copies of the meeting minutes. Furthermore, she revealed the facility had discussed the concerns during the morning stand up meeting. She explained that the kitchen monitored the temperatures on all the foods prior to starting the tray line and had not noticed any concerns with the temperatures. She revealed they used a heated plate to ensure the food stayed warm. The DM explained that she had noticed a delay in the staff getting the trays passed and had reported her concerns to the administrative staff. She revealed they (the kitchen) announced when the trays were ready,	F 565	Resident council leader will document all grievances in the Occurrences Safety Claims Accreditation Regulatory (OSCAR) electronic platform with automatic notices to assigned party, actions taken and follow up with resident documented in system. All nursing staff educated to notify dietary staff immediately of all food-related complaints on 5/5/25 by Staff Development Specialist. Resident Council concerns with actions taken are presented at the following Resident council meeting to ensure loop closure. **Facility's plan to monitor its performance to make sure that solutions are sustained: Tray temperature checks will be performed Monday-Friday by the Dietary Manager beginning 5/22/25 on ten trays for six months. Resident Council Leader will follow up with at least 3 residents monthly to ensure satisfaction with meal temperature and grievance responses beginning 5/22/25 for 5 months. The corrective action will be monitored by the Quality Assurance(QA) Coordinator completing a verification monthly during the Quality Assurance Performance Improvement (QAPI) meeting beginning 5/29/25.	

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F 565	Continued From page 3 and it was up to the staff to distribute them timely. An interview with the Administrator on 5/1/25 at 3:00 PM revealed he was aware of the complaints regarding cold food made during Resident Council meetings. He confirmed these complaints should have been written up as a grievance and they (the staff) should have a tracking process of documentation to ensure the grievances were resolved in a timely manner. Record review of the "Admission Record" revealed the facility admitted Resident #34 on 8/17/22. Record review of Resident #34's Minimum Data Set (MDS) with an Assessment Reference Date (ARD)of 4/7/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #37 on 6/8/17. Record review of the Resident #37's MDS with an ARD of 3/12/25 revealed a BIMS score of 15, which indicated the resident was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #47 on 8/5/21. Record review of Resident #47's MDS with an ARD of 3/12/25 revealed a BIMS score of 15 which indicated the resident was cognitively intact.	F 565	Grievance logs will be reviewed monthly during QAPI meetings beginning 5/29/25 ongoing.	

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F 565	Continued From page 4 Record review of the "Admission Record" revealed the facility admitted Resident #84 on 2/12/25. Record review of Resident #84's MDS with an ARD of 2/19/25 revealed a BIMS score of 15 which indicated the resident was cognitively intact.	F 565		
F 605 SS=D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2), 483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the	F 605		5/29/25

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F 605	Continued From page 5 resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 605		

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F 605	Continued From page 6 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to carry out a physician ordered gradual dose reduction (GDR) for one (1) of five (5) residents reviewed for medication. Resident #64 Findings Include: Review of the facility policy titled "Resident's Rights and Privileges" with no revision date revealed, "21. Freedom from Chemical and Physical Restraints: Residents in the proper	F 605	**Corrective actions accomplished for resident found to have been affected by the deficient practice: Resident #64's medication regimen was reviewed by Director of Nursing on 5/5/25, and necessary adjustments were made in consultation with the prescribing physician. **Identifications of other residents having the potential to be affected by the same	

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F 605	Continued From page 7 name of the facility shall enjoy freedom from chemical or physical restraints ..." Record review of the "Consultant Pharmacist Recommendation" dated September 3, 2024, revealed the physician ordered a decrease in Resident #64's Effexor (antidepressant) from 75 milligrams daily to 37.5 milligrams daily. Additionally, review of the "Consultant Pharmacist Recommendation" dated 3/21/25 revealed the physician ordered a decrease in Zyprexa (antipsychotic) 5 milligram to 2.5 milligrams at bedtime. Record review of the 4/2025 "Medication Administration Record" for Resident #64 revealed the residents continued to receive Olanzapine (Zyprexa) 5 milligrams nightly and Venlafaxine (Effexor-XR) 75 milligrams daily with breakfast. During an interview with the Interim Director of Nursing (DON) on 5/01/25 at 2:45 PM confirmed the physician ordered dose reductions for Resident #64 had never been implemented and further explained that this would have been the DON's responsibility. Additionally, she revealed the lack of not implementing these dose reductions caused Resident #64 to take more medication than was ordered to treat his depression. This could have resulted in mood changes and weight loss due to him sleeping more than usual. During an interview with the Administrator on 5/01/25 at 2:52 PM, he stated that his expectations were for the physician ordered dose reductions to be implemented by the next day. Record review of the demographics record	F 605	deficient practice: All residents who are admitted and presently reside at this facility have the potential to be affected by the deficient practice. An audit of all residents receiving psychotropic medications was conducted to ensure compliance with Gradual Dose Reduction (GDR) protocols by Director of Nursing and Assistant Director of Nursing on 5/5/25. Residents identified with similar issues had their medication regimens reviewed, and care plans updated accordingly. **Measures put into place or systemic changes to ensure the deficient practice will not recur: Complete pharmacy audit of all current GDR orders within 7 days starting 5/5/25. Collaboration with the pharmacy consultant to monitor and review psychotropic medication use on 5/5/25. Implementation of a tracking system for GDR compliance and physician order follow-ups on 5/12/25. All GDRs to be reviewed and signed by the Director of Nursing /Assistant Director of Nursing starting on 5/5/25. Scan all GDR forms into Electronic Medical Record to ensure proper	

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F 605	Continued From page 8 revealed the facility admitted Resident #64 on 3/01/23 with medical diagnoses that included Unspecified Dementia and Major Depressive Disorder, recurrent, with Psychotic Symptoms. Record review of Resident #64's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/24/25 revealed under Section C 1000 revealed the resident was moderately cognitively impaired.	F 605	documentation and tracking starting on 5/6/25. Staff training on 5/22/25 by Staff Development Specialist on the importance of adhering to physician orders and documenting medication changes. Update Gradual Reduction (GR) information during Interdisciplinary Team (IDT) meetings, especially related to behavioral medications on 5/7/25. **Facility's plan to monitor its performance to make sure that solutions are sustained: Monthly audits of medication administration records and care plans starting on 5/5/25 by Director of Nursing and Assistant Director of Nursing for five months. Conduct regular meetings with the pharmacy consultant to discuss findings and address concerns starting on 5/5/25 by Director of Nursing ongoing. Inclusion of GDR compliance as a standing agenda item in Quality Assurance Performance Improvement meetings starting 5/21/25 for five months.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 641		5/29/25

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F 641	Continued From page 9 §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to accurately complete section P of the Minimum Data Set (MDS) for one (1) of 22 sampled residents. Resident #19 Findings Include: The facility provided a statement on letterhead that revealed, "MDS (Minimum Data Set) at proper name of the facility follows the RAI (Resident Assessment Instrument) Guidelines." Record review of the MDS with an Assessment	F 641	**Corrective actions accomplished for resident found to have been affected by the deficient practice: Correction of the inaccurate Minimum Data Set (MDS) coding for Resident #19 on 5/5/25 by the MDS Coordinator. Correction of documentation in the resident's record and MDS resubmitted by 5/6/25 by the MDS Coordinator. **Identifications of other residents having	

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F 641	Continued From page 10 Reference Date (ARD) of 4/03/25 revealed under section P, a bed rail was coded as a physical restraint that was used daily. An observation on 4/29/25 at 11:27 AM revealed Resident #19 with no type of restraint in use. Record review of Resident #19's "Restraint Usage Evaluation" dated 4/03/25 revealed under, "Has any type of restraint been used in the past 7 days?" No was indicated. During an interview on 4/30/25 at 1:51 PM with the MDS Nurse #2, she revealed that the facility did not have any physical restraints in the building. She confirmed the bed rails were coded as a restraint for Resident #19 and indicated this was an error. She verbalized that she reviewed the assessments before submission, but she did not always review every section. Record review of the demographic record revealed the facility admitted Resident #19 on 9/11/20 with a medical diagnosis that included Vascular Dementia. Record review of the MDS with an ARD of 4/03/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 4, which indicated Resident #19 was severely cognitively impaired.	F 641	the potential to be affected by the same deficient practice: All residents who are admitted and presently reside at this facility have the potential to be affected by the inaccurate reflection in the MDS. Audit was performed on 5/5/25 of recent MDS assessments to identify and correct any additional coding errors by the MDS Coordinator. Corrections were submitted on 5/6/25 by the MDS Coordinator. Review of coding practices for accuracy and compliance with guidelines was performed on 5/5/25 by the MDS Coordinator. **Measures put into place or systemic changes to ensure the deficient practice will not recur: There were technical issues in the Electronic Medical Record (EMR) affecting mapping of data being pulled into the 802 form. The 802 form is a tool used by Nursing Homes to track specific resident information. The macro solution was implemented in the EMR for MDS nurses to ensure consistent documentation on 5/6/25. Utilization of software tools to flag potential coding inconsistencies. Continuous education annually for MDS nurses on updates to MDS coding guidelines by Myers and Stauffer on	

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F 641	Continued From page 11	F 641	5/21/25 and 10/25. **Facility's plan to monitor its performance to make sure that solutions are sustained: Monthly audits to include ten percent of MDS assessments for a total of 5 months for accuracy starting on 5/29/25 by MDS nurses. Regular feedback sessions with MDS coordinators to discuss audit findings at Quality Assurance Performance Improvement meetings on 5/29/25. Generate the EMR restraint log and cross-reference against the 802 form weekly for accuracy by MDS Coordinator starting on 5/29/25. The results of the audits will be at upcoming Quality Assurance Performance Improvement meeting on 5/29/25 and monthly for six months to verify accuracy.	
F 656 SS=J	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		5/29/25

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F 656	Continued From page 12 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to implement a	F 656	**Corrective actions accomplished for resident found to have been affected by the deficient practice:	

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F 656	Continued From page 13 comprehensive care plan for 1) for Resident #16 who was a known risk for sexual behaviors towards others, to prevent the resident from entering Resident #56's room and sexually assaulting her while she lay in her bed, 2) transfer assistance for a dependent resident (Resident #5), and 3) assistance with Activities of Daily Living (ADL) (Resident #40, #90, and #92) for five (5) of 22 resident care plans reviewed. Resident's # 5, #16, #40, #90 and #92. This facility failed to implement the sexual behavior care plan for Resident #16 which led to Resident #56 being sexually assaulted in her room on 4/24/25 at approximately 3:00 PM, when a Certified Nursing Assistant (CNA) observed Resident #16 in the bed on top of Resident #56, with his hand inside her incontinence brief, performing jabbing motions. 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 death. This situation was determined to be an Immediate Jeopardy (IJ) 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	F 656	Resident #5's incident was reviewed, and appropriate care plan updates were reviewed on 2/7/25 by Care Plan Nurse. Resident #56's care plan was immediately reviewed and revised by the interdisciplinary team to reflect current needs and appropriate interventions on 4/25/25 by Care Plan Nurse. Resident #16 was closely monitored and protective measures were put in place to assure safety and well-being for other residents and revisions added to the care plan on 4/25/25 by Care Plan Nurse. Immediate provision of fingernail care to Residents #40, 90, and 92 on 5/2/25 by Assistant Director of Nursing. **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 provided on 5/16/25 by Staff Development Specialist to all nursing staff regarding comprehensive care plan.	

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F 656	Continued From page 14 IJ 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 were completed on 5/01/25, and the IJ removed on 5/02/25. The SA validated the Removal Plan on 05/05/25 and determined the IJ was removed on 5/02/25, prior to exit. Therefore, the scope and severity for 42 CFR: 483.21(b) Comprehensive Care Plans - (F656) - Scope and Severity "J" was lowered from a scope and severity of "J" to a "D" 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 facility policy titled, "Care Plans" with a revision date of 11/07/2023, revealed, "An individualized Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs is developed for each resident." Record review of facility policy titled, "Purposes of a Nursing Care Plan" dated, 03/14/2024, revealed, "Following the resident's current individualized care plan is crucial and a legal duty as a clinical care team member. Following the resident's current care plan ensures we as a team are providing the best care for each resident."	F 656	All residents care plans were reviewed and updated by Care Plan Nurse on 5/1/25. 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 to make sure that solutions are sustained: The corrective action will be monitored by the Quality Assurance nurse completing "Care Plan Review Audit" weekly starting on 5/22/25. This audit will contain a review of ten percent of the facility residents for six months. This deficiency, the corrective action and any further problems noted will be presented to the Quality Assurance Performance Improvement committee meeting on 5/29/25 and monthly for six months with review and recommendations as needed.	

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Resident # 16

Cross Reference F600

Record review of the "Encounter Problems (Active)" for Resident #16 revealed "Problem: Mood/Behaviors", with a start date of 11/4/24, "Description: I exhibit sexually inappropriate behaviors ..." Review of intervention description revealed " ...Protect the rights and safety of others ...Elder and others will not experience harm from agitated behaviors ..."

Record review of the facility investigation 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.

During an interview with the Care Plan Nurse on 5/01/25 at 8:55 AM she confirmed that staff did not follow the care plan related to Resident #16's sexual behaviors and therefore did not protect the safety of others. She revealed the purpose of the comprehensive care plan is to identify any specific resident needs and direct staff of resident specific care needed.

Review of the removal plan revealed that the

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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 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 were 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 04/24/2024 at 4:21 PM, Nursing Home Medical Staff Director (NHMSD) notified by phone by RN 1 of findings from body audit. No orders

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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.

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.

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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.

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.

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24. No staff, including the Director of Nursing, will be allowed to work until they are 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 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 alleges Immediate Jeopardy was removed as of 5/2/25.

Validation:

The State Agency (SA) validation of the Removal

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Plan was made on-site during the survey through record review and interviews on 5/5/25. The SA determined all corrective actions were completed on 5/2/25 and the IJ was removed on 5/2/24.

Resident #5

Record review of 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 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)".

On 4/30/25 at 9:00 AM, in an interview with CNA #5 she stated that she and CNA #4 were assigned to take care of Resident #5 on 1/27/25.

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She stated that CNA #4 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 #4 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#4 on the technique because she had never transferred a resident in this way and did not think it was correct, but that CNA #4 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 #4 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 #4 had transferred her before.

On 5/2/25 at 12:00 PM, during a telephone interview with CNA #4, she stated that on 1/27/25 she and CNA #5 went in to assist Resident #5 to the wheelchair to transport her to another room. She stated that she told CNA #5 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 her to

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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 #4 stated that she always transferred Resident #5 this way and had no problems. She stated she felt like CNA #5 did not have a good hold on the resident during the transfer. CNA #4 admitted that she did not use a walker when transferring the resident, stating that she had never used a walker when transferring the resident. CNA #4 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.

During an interview with the Care Plan Nurse on 5/01/25 at 8:53 AM, she revealed the purpose of the comprehensive care plan is to identify any specific resident needs and direct staff of resident specific care needed. She also verified that the CNAs are to check the resident ADL Care plans weekly & sign that they have checked them. She revealed after reviewing the ADL care plan for Resident #5 staff did not follow the care plan related to transfers if staff did not use a walker as specified during the resident's transfer.

Record review of the demographic page for Resident # 5 revealed the facility admitted her on 6/14/24.

Resident #40

Record review of Resident #40's Care Plan revealed that she had Diabetes Mellitus, and the

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description of care to be received with a start date of 11/25/24 revealed, "Diabetic nail care weekly per 7/3 RN."

On 4/29/25 at 11:13 AM an observation and interview Resident #40 revealed she liked her fingernails short. She stated she could not remember the last time they were trimmed. This observation confirmed that Resident #40's fingernails long past the tips of her fingers and jagged.

On 4/30/25 at 2:22 PM, during an observation and interview Registered Nurse (RN) #1 confirmed that Resident #40's nails looked like it had been a while since they were tended to. She confirmed they were long and jogged, and that the residents plan of care had not been followed. She further stated that the RN's were supposed to do nail care with their weekly body audits.

In an interview on 4/30/25 at 3:17 PM, Minimum Data Set (MDS) Nurse #1 confirmed that if Resident #40's nail care was not being done as it was supposed to have been, then it is safe to say that her care plan was not being followed. She revealed she is responsible for developing the residents' care plans and they are developed to identify and address each resident's needs so the staff will know how to care for each resident.

Review of the Resident #40's demographic page revealed the resident was admitted to the facility on 5/18/2021 with medical diagnoses of Type 2 Diabetes Mellitus with Diabetic Nephropathy.

Record review of Resident #40's Section C of the Annual MDS dated 2/25/2025 revealed the BIMS score was 12, indicating the resident has

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moderate cognitive impairment.

Resident #92

Record review of Resident #92's "CNA Care Plan" with a start date of 11/25/24 revealed, "...nail care weekly..."

Record review of Resident #92's "Skin Care Plan" with a start date of 11/25/24 revealed, "Finger and toenail care with trimming weekly as needed per RN Supervisor."

On 4/29/25 at 11:31 AM an observation and interview revealed Resident #92's fingernails were long and dirty. The resident's nails appeared to be approximately ½ (one-half) inch long and had a brown substance under the nail beds. Resident #92 stated that he had asked them to cut and clean, and they always say they will get back to me.

On 4/30/25 at 11:15 AM, during an observation CNA #1 confirmed that Resident #92's fingernails were long and dirty. She confirmed that the CNA's are responsible for cleaning the residents' nails.

An observation and interview on 4/30/25 at 11:35 AM, LPN#1 confirmed that Resident #92's nail care, which is in his care plan, was not being followed, and it should have been. She confirmed that the resident's nails needed trimming and cleaning.

In an interview on 4/30/25 at 3:05 PM, MDS Nurse #1 revealed that Resident #92's care plan was not followed if his fingernails were long and unkempt.

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BAPTIST NURSING HOME-CALHOUN, INC	152 BURKE CALHOUN CITY ROAD CALHOUN CITY, MS 38916

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F 656	Continued From page 25	F 656		

Record review of the Resident #92's demographics revealed the resident was admitted to the facility on 3/5/2024 with medical diagnoses including Metabolic Encephalopathy.

Record review of Resident #92's Section C of the Annual MDS dated 2/20/2025 revealed the BIMS score was 11, indicating the resident has a moderate cognitive impairment.

Resident #90

Record review of "CNA Care Plan" with start date 11/6/24 revealed, "...nail care weekly..."

An observation on 4/29/25 at 11:08 AM revealed Resident #90's fingernails were long and jagged with a brown substance under the nail beds.

On 4/30/25 at 11:41 AM during an observation and interview with Licensed Practical Nurse (LPN) #3, she confirmed that Resident #90's fingernails were long with a brown substance underneath and needed cleaning and clipping.

During an interview on 5/5/25 at 10:00 AM with the Care Plan Nurse, she confirmed Resident #90's care plan was not followed. She revealed that failure to follow the care plan could result in the residents' nails remaining unclean.

Record review of "Demographics" revealed the facility admitted Resident #90 on 2/15/24 with primary diagnosis of Alzheimer's Dementia.

Record review of Resident #90's MDS with an ARD of 2/5/25 revealed a BIMS score of 7, which

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F 656	Continued From page 26 indicated the resident had moderate cognitive impairment.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to provide care to maintain personal hygiene for three (3) of 95 residents in the facility. Resident #40, #90, and #92. Findings include: Review of facility policy titled, "Activities of Daily Living (ADL'S) last review date 4/3/18, revealed, "Policy...to assist residents in achieving maximum function with Activities of Daily Living...will provide assistance to residents as necessary...". Resident #40 An observation and interview on 4/29/25 at 11:13 AM revealed Resident #40's fingernails to be approximately 3/4th (three-fourth) inch long and jagged past the tips of the fingers. Resident #40 stated she would like them to be shorter, and she wasn't sure the last time that her fingernails were trimmed. An interview and observation on 4/30/25 at 11:25 AM, Certified Nurse Aide (CNA) #1 confirmed the	F 677	**Corrective actions accomplished for resident found to have been affected by the deficient practice: Immediate provision of fingernail care to Residents #40, 90, and 92 on 5/2/25 by Assistant Director of Nursing. **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 provide Activities of Daily Living care. **Measures put into place or systemic changes to ensure the deficient practice will not recur: Staff education provided on 5/5/25 by the Staff Development Specialist on the importance of personal hygiene and grooming as part of Activities of Daily Living.	5/29/25

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F 677	Continued From page 27 resident's fingernails were long and revealed that the nurses are responsible for cutting the resident's fingernails. During an interview and observation on 4/30/25 at 12:05 PM, Licensed Practical Nurse (LPN) #1 revealed the Registered Nurses (RN) are supposed to do the weekly fingernail care for each resident. She confirmed the resident's fingernails were long and jagged, and she wasn't sure when the last time they were cut. During an interview on 4/30/25 at 2:22 PM, Registered Nurse (RN) #1 revealed nail care is supposed to be done by an RN weekly when they do the body audit. She confirmed the resident's nails were long and jagged and revealed it looked like it had been quite some time since her fingernails were tended to. A record review of Resident #40's Orders revealed, "Nail Care Routine, Weekly." Record review of the resident demographics revealed Resident #40 was admitted to the facility on 5/18/2021 with a medical diagnoses that included Type 2 Diabetes Mellitus with Diabetic Nephropathy. Record review of Resident #40's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/25/2025 revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident has moderate cognitive impairment. Resident #92 An observation and interview on 4/29/25 at 11:31 AM revealed Resident #92's fingernails to be	F 677	Integration of fingernail care into the routine Certified Nursing Assistant's flow sheets and care plans on 5/5/25. **Facility's plan to monitor its performance to make sure that solutions are sustained: Weekly audits of Activities of Daily Living documentation and resident appearance by RNs weekly for four weeks, then monthly for five months of ten percent of all residents starting on 5/21/25. A new Quality Assurance tool was implemented on 5/22/25 to specifically tracking Activities of Daily Living and personal hygiene (with a focus on nail care). Results of the Quality Assurance audit tool will be presented at Quality Assurance Performance Improvement meeting on 5/29/25. Monthly staff meetings held by Director of Nursing/Assistant Director of Nursing to discuss findings and reinforce best practices starting on 5/20/25.	

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F 677	Continued From page 28	F 677		

approximately ½ (one-half) inch long past the tips of his fingers, dirty in appearance, with a brown substance under the nail beds. Resident #92 stated, "I've told them I need them cut, and they say I'll get back to you." He stated "These fingernails are just too long. If I could get a hold of my son, I would have him bring me in some fingernail clippers, and I'll do it myself."

An observation on 4/30/25 at 8:40 AM revealed Resident #92's fingernails remain unchanged from the previous day.

An observation on 4/30/25 at 11:15 AM, CNA #1 revealed that she was assigned to Resident #92 and confirmed that his fingernails were long and dirty with a brown substance underneath. She revealed that we can clean underneath the resident's fingernails, but the CNAs cannot cut them. She stated, "I think he will get his bed bath today, and we will clean his fingernails."

An observation and interview on 4/30/25 at 11:35 AM, LPN#1 confirmed that CNAs are responsible for cleaning the fingernails each time the resident gets bathed. She confirmed that Resident #92's fingernails were long, jagged, and dirty. She stated, "Wow, these need to be cut." She confirmed it looked like it had been a while since his fingernails were cut and cleaned, revealing that he could scratch himself and cause a skin tear or infection with his nails being that long and jagged.

A record review of Resident #92's Orders revealed, "Nail Procedure Routine, Weekly, Finger and toenail care weekly as needed per RN Supervisor."

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F 677	Continued From page 29	F 677		

Record review of the resident demographics revealed Resident #92 was admitted to the facility on 3/5/2024 with a medical diagnosis of Metabolic encephalopathy.

Record review of Resident #92's MDS with an ARD of 2/20/2025 revealed a BIMS score of 11, indicating the resident has a moderate cognitive impairment.
Resident #90

During an observation on 4/29/25 at 11:08 AM, Resident #90 was found lying in bed with eyes closed. Notably, his fingernails were approximately 3/4 inch long, appeared dirty, and had jagged edges with a brown substance underneath.

During an observation and interview on 4/30/25 at 11:41 AM with LPN #3, she confirmed that Resident #90's fingernails were approximately 3/4 inch long with a brown substance underneath, jagged edges and needed cleaning and clipping. The LPN stated that CNAs are responsible for cleaning underneath the fingernails but cannot cut them per facility policy. She noted that the CNAs should have performed this cleaning during the residents' bath. The LPN emphasized that nurses are required to trim nails. She further mentioned that Resident #90 tends to "dig," which makes it important for his nails to be kept clean and trimmed, as unkempt nails could lead to infection.

During an interview on 5/5/25 at 10:24 AM with the Interim Director of Nursing (DON), she confirmed that nail care should be performed during showers and as needed.

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F 677	Continued From page 30 Record review of "Demographics" revealed the facility admitted Resident #90 on 2/15/24 with primary diagnosis of Alzheimer's Dementia. Record review of Resident #90's MDS with an ARD of 2/5/25 revealed in Section C a BIMS score of 7, which indicated the resident had moderate cognitive impairment.	F 677		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		5/29/25

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F 761	Continued From page 31 Based on observation, staff interview, and facility policy review, the facility failed to ensure medications were stored appropriately for one (1) of 95 residents residing in the facility. Resident # 32 Findings Include: Review of the facility policy titled "Administration for Oral Medications" unrevised, revealed under, "Policy: It is the policy of proper name of the facility that all services provided or arranged by the facility must meet professional standards of quality." Record review of the "Nursing Department QA (Quality Assurance) for Med Pass" revised 2/15/12 revealed, "Ensure that resident has taken and swallowed medication". An observation of Resident #32 on 4/29/25 at 11:40 AM revealed she was lying on her left side in bed with her eyes closed. A clear medication cup was observed sitting on the bedside table with seven (7) pills inside. An observation and interview with Licensed Practical Nurse (LPN) #2 on 4/29/25 at 11:50 AM confirmed that Resident #32's medications were left at the bedside. She revealed that the medication was the resident's morning medication and explained that she had entered the resident's room earlier in the morning to administer them, but the resident was asleep. She revealed she should have taken the medications back with her to secure them, in order to prevent another resident from accessing them.	F 761	**Corrective actions accomplished for resident found to have been affected by the deficient practice: Immediate removal of unattended medications from Resident #32's bedside on 4/29/25. Assessment of the resident for any adverse effects and documentation of findings. **Identifications of other residents having the potential to be affected by the same deficient practice: All residents who are admitted and presently reside at this facility have the potential to be affected by the failure to follow safe medication administration practices. **Measures put into place or systemic changes to ensure the deficient practice will not recur: Education of nursing staff on 5/22/25 by Staff Development Specialist on proper medication administration and monitoring protocols. Education of nursing staff on 5/22/25 by Staff Development Specialist on the double-check system to ensure medications are administered and monitored appropriately. **Facility's plan to monitor its performance to make sure that solutions are sustained:	

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F 761	Continued From page 32 An interview with the Interim Director of Nursing (DON) on 4/29/25 at 12:16 PM confirmed that the nurse should have taken the Resident #32's medication with her when she left the room to ensure that no one else accessed it. She agreed that many things could happen when medications are left at a resident's bedside such as, another resident could take them, or a family member could come in and take them home. Record review of Resident #32's "Demographic Record" revealed the facility admitted the resident on 2/10/17 with medical diagnoses that included Acute on Chronic Heart Failure. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/29/25 revealed under section C, a Brief interview for Mental Status (BIMS) summary score of 13, which indicated Resident #32 was cognitively intact.	F 761	Registered Nurses conduct observations of at least twenty medication passes monthly to ensure compliance and identify trends starting on 5/22/25 for six months. The Quality Assurance audits will specifically be targeting medication administration, accuracy, and technique. Registered Nurses will record findings and provide feedback immediately. This review will be presented to the Quality Assurance Performance Improvement committee meeting on 5/29/25 and monthly for six months with review and recommendations as needed. Monthly review of medication error reports and implementation of corrective actions started on 5/21/25. This review will be presented to the Quality Assurance Performance Improvement committee meeting on 5/29/25 and monthly for six months with review and recommendations as needed.	
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and	F 868		5/29/25

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F 868	Continued From page 33 (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to ensure quarterly Quality Assurance and Performance Improvement (QAPI) committee meetings were held at least quarterly with the mandatory staff present for two (2) of the most recent four (4) quarters. November 2024 and February 2025 Findings include: Record review of facility policy titled "Quality Assurance and Performance Improvement", with revision date of October 2024, revealed, "All	F 868	**Corrective actions accomplished for resident found to have been affected by the deficient practice: Immediate scheduling of overdue Quality Assurance Performance Improvement meetings. Completed 5/1/25. **Identifications of other residents having the potential to be affected by the same deficient practice: All residents who are admitted and	

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F 868	Continued From page 34 QAPI (Quality Assurance and Performance Improvement) activities will be unified across all areas of care and services at our facility. There will be a representative of each area of service on the QAA Committee. Each area will be discussed regardless of whether the representative is present or not. All areas will work together to combine care and services across our continuum of care to better meet the needs of the elders living in our facility". Record review of "Monthly Quality Assurance/Improvement Meeting" sign-in sheets revealed the facility had not had a Quality Assurance meeting since 08/2024. During an interview on 5/2/25 at 11:21 AM, the Interim Director of Nursing (DON) confirmed that the facility failed to hold quarterly QAPI meetings with the mandatory staff members present and admitted that she could not find evidence of a meeting since 08/2024. She stated that the hospital and the facility had a combined monthly QAPI meeting but admitted that the required staff were not present. During an interview on 5/2/25 at 12:00 PM, the Administrator confirmed the facility failed to hold a quarterly QAPI meeting with the required staff members present. He stated he took over the position of Administrator on 2/25/25, admitted that he had not held a facility QAPI meeting since he started. During a phone interview on 5/2/25 at 12:05 PM, the Medical Director confirmed there was a scheduled QAPI meeting on 4/16/25, which was canceled, and this meeting was not rescheduled	F 868	presently reside at this facility have the potential to be affected by the deficient practice of not having timely Quality Assurance Performance Improvement meetings. Review of all quality assurance meeting minutes and sign in sheet to identify lapses in compliance on 5/20/25 by Nursing Home Administrator. Assessment of departmental participation in Quality Assurance Performance Improvement initiatives on 5/20/25 by Nursing Home Administrator. **Measures put into place or systemic changes to ensure the deficient practice will not recur: Establishment of a Quality Assurance Performance Improvement calendar with scheduled meetings and required members attendance on 5/14/25 by Director of Nursing. Training for department heads on 5/21/25 by Staff Development Specialist on Quality Assurance Performance Improvement processes and expectations. Development of a tracking system to monitor Quality Assurance Performance Improvement meetings, minutes and outcomes started on 5/21/25. **Facility's plan to monitor its performance to make sure that solutions are sustained:	

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F 868	Continued From page 35	F 868	Monthly audits of Quality Assurance Performance Improvement meeting attendance and documentation for six months, then every two months for six months, then quarterly started on 5/21/25 by Quality Assurance Nurse. Regular evaluation of Quality Assurance Performance Improvement outcomes and effectiveness. Continuous improvement initiatives based on Quality Assurance Performance Improvement findings.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		5/29/25

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F 880	Continued From page 36	F 880		

conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A233	A. BUILDING _____ B. WING _____	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

(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) COMPLETION DATE
F 880	Continued From page 37 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: 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. 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	F 880	**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 Development Specialist. Nursing staff to round daily and confirm signage is present on 5/21/25.	

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F 880	Continued From page 38 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 which indicated the resident had severe cognitive impairment.	F 880	Add compliance to Quality Assurance Performance Improvement tracking and infection control audits. **Facility's 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.	