

MSDH - Health Facilities Licensure and Certification

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>07CC</b>                                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C</b><br><b>06/05/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BAPTIST NURSING HOME-CALHOUN, INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>152 BURKE CALHOUN CITY ROAD</b><br><b>CALHOUN CITY, MS 38916</b> |                                                                                                                          |                                                                      |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                             |
| {M 000}                                                                      | <p>Initial Comments</p> <p>On 06/05/25 the State Agency (SA) conducted an onsite revisit related to the annual survey that was completed on 05/05/25. The information reviewed confirmed the facility had put measures in place to correct the deficient practice and sustain compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm. The SA is recommending that your facility be placed back in compliance effective 05/29/25.</p> <p>The census at the time of the survey was 93 and the facility held a license for 120 beds.</p> | {M 000}                                                                                                      |                                                                                                                          |                                                                      |

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/11/25