STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A233	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST NURSING HOME-CALHOUN, INC	**152 BURKE CALHOUN CITY ROAD , CALHOUN CITY, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI), MS #2597732 at the facility on 08/25/25. MS #2597732 was investigated for infection control concerns. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited infection control deficiency at F880. The census at the time of the survey was 93 with a license for 120 beds.	F0000		
F0880 SS = F	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 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	F0880		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0880 SS = F	Continued from page 1 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 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 observations, interviews, record reviews and policy and procedure reviews, the facility did not follow established infection control procedures for the transportation, handling, and disturbing of dirty and clean linens. The facility used the public laundry and	F0880		

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F0880 SS = F	Continued from page 2 transported the dirty and clean linens in the facility van that was for resident use without cleaning the van/bus before and after each use. The facility also used public washing machines without cleaning them before and after each use and for not using hot water temperatures in accordance with infection control policies and procedures. The deficient practice had the potential to affect 93 of 93 residents living in the facility and all staff. Findings Include: The facility policy titled: “Laundry Services” undated, read: “To assure a clean supply of linens and to protect employees who handle and process the laundry.” Soiled linen should be handled as little as possible and with a minimum of agitation to prevent gross microbial contamination of the air and of persons handling the linen. All linens should be stored and transported in carts used exclusively for this purpose, or in linen carts that have been decontaminated after being used for soiled laundry. Dirty linen should be clearly separated from areas where clean linen is handled. Linens should be washed with a detergent in water hotter than 160 degrees Fahrenheit (F) for 25 minutes since this is an effective method for cleaning and for killing most vegetative bacteria. Observation and interview on 08/25/25 at 11:45 AM with the Director of Nursing (DON) confirmed that the facility laundry department had three (3) broken washing machines. DON toured the facility laundry with the State Agency (SA) and stated that they had been transporting the facility laundry to the public laundry facility in the local town. The laundry staff were placing the dirty facility linens in the facility’s resident transport van/bus and taking the linens to be washed and dried and transported back to the facility in the resident transport van/bus. DON stated that there were three (3) commercial “high temperature” washing machines located in the facility laundry and that all three (3) were broken. The DON confirmed that the nursing home facility was located next to the community hospital and Emergency Room (ER) and there was only one laundry department that the hospital and the nursing home shared. The three (3) commercial washing machines were used to wash all the linens for the nursing home, the community hospital, and the ER. Therefore, since all three (3) commercial washers were broken and un-usable the laundry staff have to transport the linens for all the nursing home, the community hospital and the ER to the local public laundry facility for washing and drying. DON stated that the maintenance department had attempted to repair	F0880		

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F0880 SS = F	Continued from page 3 the washing machines, but the correct parts had not been obtained to do the repairs. Observation was made in the laundry area that there were three (3) commercial “high temperature” washing machines that had signs attached to all three (3) “Out of Order.” The DON stated that the commercial washing machines were over 30 years old and probably needed to be replaced. DON stated that to her knowledge the facility had been using the local public laundry facility for washing the facility’s linens for approximately two (2) weeks.On 08/25/25 at 12:00 PM an interview with the Maintenance Director revealed that the facility had no way of repairing the washing machines without the proper parts and that the parts were ordered and the wrong part was sent, and they had to re-order and he had no timeframe of when the repairs would be completed. Maintenance Director confirmed that all three washing machines were broken down and unusable and stated, “I don’t know how it happened, probably because they are worn out.” Interview on 08/25/25 at 12:40 PM with Licensed Practical Nurse (LPN) #1 confirmed that Resident #1 was on contact isolation because of Extended-spectrum Beta-Lactamase (ESBL) which required contact isolation. LPN #1 confirmed that Resident #1 had to have all linens and personal clothing placed in red bags for infectious waste and washed separately from all other residents' linens and clothing. Interview on 08/25/25 at 1:00 PM with Registered Nurse (RN) #2 revealed that Resident #3 was on contact precaution due to Carbapenem-resistant Pseudomonas aerogenesis (CRPA) of the urine. Record review of the facility roster matrix dated 08/25/2025 revealed that two (2) residents, Resident #1 and Resident #3, were documented as being placed on Transmission-Based Precautions (TBP). Interview on 08/25/25 at 1:15 PM with the Laundry Director revealed that she has been loading the linens into the facility’s resident transport van/bus and transporting the dirty linens to the public laundry facility and washing them in the public washing machines and dryers and transporting them back to the facility. She sorts the laundry in the facility laundry department and places the dirty towels and bed linens inside of plastic bags and then puts them in the van and drives the dirty linen to the public laundry facility. She confirmed that she does not disinfect the van/bus and does not place any type of barrier down inside of the van/bus when transporting the dirty linens or the clean linens. Laundry Director confirmed that she does not disinfect the public washing machines prior to use and does not disinfect after use and had no way to monitor the temperature to ensure that the washer water temperature had to reach a minimum of 160-degree F in order for the detergent to break down and sanitize the linens. Laundry Director stated that	F0880		

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F0880 SS = F	Continued from page 4 the first facility commercial “high temperature” washing machine had been broken for approximately three (3) weeks and then approximately two (2) weeks ago the second and third facility high temperature commercial washing machines broke down, leaving them without washing machines. Laundry Director stated that all resident clothes and all red bags were washed in the facility in the small “household” washing machine and those were not taken to the public facility. Laundry Director stated that the small “household” washing machine located in the facility laundry department had no temperature gages and she had never used a thermometer to take the hot water temperature.	F0880		