

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115264	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025
NAME OF PROVIDER OR SUPPLIER Calhoun Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 265 Turner Street Edison, GA 39846	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>36377</p> <p>Based on observations, staff and resident interviews, record review, and review of the facility policy titled, Quality of Life - Dignity, the facility failed to promote care in a manner that maintained the resident's dignity and respect for one of 28 sampled residents (R) (R9). Specifically, staff provided personal hygiene and bathing assistance to R9 without providing full visual privacy by ensuring window blinds were closed and the privacy curtains encircled the bed. This failure had the potential to diminish the resident's quality of life in an environment that promotes the maintenance or enhancement of each resident's quality of life.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Quality of Life - Dignity, dated 2009, revealed the Policy Statement stated, Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. The Policy Interpretation and Implementation section included, 1. Resident shall be treated with dignity and respect at all times.</p> <p>Review of R9's electronic medical record (EMR) revealed diagnoses including, but not limited to, chronic kidney disease stage three, primary pulmonary hypertension, unspecified atrial fibrillation hypertension, and presence of cardiac pacemaker.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment, dated 3/31/2024, revealed Section C (Cognitive Patterns) documented a Brief Intensive Mental Status (BIMS) score of 11(indicating moderate cognitive impairment). Section GG (Functional Abilities and Goals) documented that R9 was assessed for total care dependence for personal hygiene care and shower/bath.</p> <p>Review of R9's care plan revealed a Problem created 3/24/2025, of the resident required assistance with activities of daily living (ADL). Approaches included staff to provide substantial/maximal dependent care for bathing.</p> <p>During an observation on 4/30/2025 at 9:40 am, Certified Nursing Assistant (CNA) FF was observed assisting R9 with a bed bath and personal hygiene care with the privacy curtains not pulled and the window blinds open. Observation revealed R9 resided in bed A of a two-bed room and another resident also resided in the same room. Further observation revealed R9 was lying in bed, unclothed except for a brief. The resident in the B bed was observed looking at R9. Continued observation revealed that the window faced the parking area for the facility.</p> <p>(continued on next page)</p>

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 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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During the second observation on 4/30/2025 at 9:43 am of R9 with Licensed Practical Nurse (LPN) BB, observation revealed the privacy curtains had been pulled closed halfway on one side of the bed leaving the end of the bed open (resulting in the curtain not encircling the entire bed) and the window blinds remained open allowing a view of the resident's room from the parking area. Further observation revealed R9 was fully unclothed, and CNA FF was providing a bed bath. LPN BB informed CNA FF that the privacy curtain should have been pulled to encircle the bed, and the window blind should have been closed. LPN BB closed the window blinds and assisted with pulling the privacy curtains. CNA FF verified her failure to pull the privacy curtain and close the window blinds. CNA FF stated she was unaware that the curtain should be pulled around the resident and the window blinds should be closed.</p> <p>In an interview on 4/30/2025 at 1:10 pm, R9 stated CNA FF did not pull the privacy curtain or close the window blinds during her bath. She further stated she did not want other residents or anyone in the parking lot to see her unclothed, stating it was embarrassing to her.</p> <p>In an interview on 5/1/2025 at 4:00 pm, the Director of Nursing (DON) stated that her expectations were for staff to close privacy curtains and window blinds to ensure residents' privacy was maintained during ADL care.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>36377</p> <p>Based on observations, resident and staff interviews, and record review, the facility failed to ensure supervision was provided during resident showers for two of 28 sampled residents (R) (R39 and R57). This deficient practice had the potential to place R39 and R57 at risk of avoidable injuries.</p> <p>Findings include:</p> <p>1. Review of R39's electronic medical record (EMR) revealed diagnoses including, but not limited to, chronic kidney disease, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.</p> <p>Review of R39's Quarterly Minimum Data Set (MDS) assessment, dated 4/2/2025, revealed Section C (Cognitive Patterns) documented a Brief Interview Mental Status (BIMS) score of 15 (indicating little to no cognitive impairment). Section GG (Functional Abilities and Goals) documented R39 required partial to moderate assistance for a bath or shower.</p> <p>Review of R39's Fall Risk Assessment, dated 4/2/2025, revealed a score of 12 (indicating a high risk for fall) and a risk with balance while standing.</p> <p>Review of R39's care plan revealed a Problem area dated 6/7/2022, that R39 required independent to partial/moderate assistance with activities of daily living (ADLs) due to cerebral vascular accident (CVA) with right-sided hemiplegia (complete or partial paralysis) Approaches included staff to provide partial moderate assistance with bathing.</p> <p>A concurrent observation and interview on 4/29/2025 at 10:08 am revealed R39 sitting in a shower chair in the shower cubicle. R39 was unclothed, covered in soap suds, and water from the shower was spraying on her. Further observation revealed there was no staff in the shower room. Continued observation revealed that the call light was not within reach for the resident's use. During an interview, R39 stated that he was unable to transfer himself independently without falling in the shower due to limited mobility of his left hand. R39 reported being uncertain about how long he had been in the shower and unattended by staff. R39 stated that a Certified Nursing Assistant (CNA) had brought him into the shower and stated that she would be back, but the CNA never came back. R39 continued to state that the CNA often left him unattended in the shower room and normally returned once his shower was over.</p> <p>During a concurrent observation and interview on 4/29/2025 at 10:10 am, Licensed Practical Nurse (LPN) BB confirmed that R39 was left in the shower room unsupervised by staff. LPN BB verified that the resident required assistance/supervision with his shower and that a CNA should have been in the shower room with the resident. LPN BB then exited the shower room to look for the assigned CNA.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a concurrent observation and interview on 4/29/2025 at 10:14 am, LPN BB returned to the shower room and stated that CNA AA was assigned to the resident and was currently providing services to another resident. She further stated that CNA AA informed her that the normal routine was to leave R39 unsupervised in the shower to bathe independently, and once the resident was ready, the CNA would assist the resident back to his room. LPN BB then exited the shower room and returned to the hallway, leaving the resident alone in the shower.</p> <p>On 4/29/2025 at 10:16 am, CNA AA returned to the shower room to assist R39. CNA AA confirmed that she had left R39 in the shower by himself. She stated that R39's preference was to be left in the shower alone, and that she normally left him alone in the shower room.</p> <p>In an interview on 4/30/2025 at 10:18 am, R39 stated that his preference was for staff to remain in the shower room while he independently washed himself. He continued to describe his preference as having the privacy curtains pulled and the CNA remaining in the shower room to ensure his safety. He further stated that staff often told him they had other things to do and did not return to the shower room, and he felt unsafe being left alone in the shower room.</p> <p>In an interview on 5/1/2025 at 9:08 am, the Director of Nursing (DON) confirmed that R39 required partial to moderate assistance with bathing and showering. She described a partial to moderate assistant as staff helping the resident, and the resident doing partial care. She further stated R39 was at risk for falls, and she expected staff to remain in the shower room with him during his showers.</p> <p>2. Review of R57's EMR revealed diagnoses including, but not limited to, type two. diabetes mellitus without complications, moderate intellectual disabilities, persistent atrial fibrillation, and hypertension.</p> <p>Review of R57's Admission MDS assessment, dated 3/17/2024, revealed Section C (Cognitive Patterns) documented a Brief Interview Mental Status (BIMS) score of 8 (indicating moderate cognitive impairment). Section GG (Functional Abilities and Goals) documented R57 required supervision for a bath or shower.</p> <p>During a concurrent observation and interview on 4/29/2025 at 10:33 am with the DON, R57 was observed sitting in a shower chair in a shower cubicle, unsupervised, with the water running over the resident and soap suds covering the resident. The DON verified that the resident was in the shower room unattended and no staff were in the room. The DON stated that R57 should not have been left in the shower room unattended. The DON exited the shower room to locate R39's assigned CNA.</p> <p>In an interview on 4/29/2025 at 10:36 am, CNA EE confirmed that R57 had been left unattended in the shower room.</p> <p>In an interview on 4/29/2025 at 10:45 am, CNA DD confirmed that she had left R57 unattended in the shower room.</p> <p>In an interview on 4/30/2025 at 9:33 am, R57 stated he was left unattended in the shower room by the CNA. He stated he was left unattended for several minutes, and he was often left unattended in the shower room. He further stated he was afraid of fainting or falling in the shower.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 5/1/2025 at 9:06 am, the DON stated supervision for shower or bath meant that staff would not leave the resident unattended and would remain in the shower room at all times.</p> <p>In an interview on 5/1/2025 at 12:30 pm, the Administrator stated they were unaware of residents being left unattended while showering.</p> <p>A policy requested but was not provided.</p>		