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

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)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 48845 Based on resident and staff interview, record 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. 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. (continued on next page)

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, 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. 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.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 47158 Based on staff interview, record review and facility policy review, the facility failed to notify a Resident Representative (RR) following an accident for one (1) of three (3) residents reviewed for notifications of change. Resident #5. Cross Reference F689, F656 Findings Included: Record review of the facility policy titled Notification of Changes revealed, Policy: i. To immediately notify the resident, consult with the resident's physician, and if known, notify the resident's legal representative or interested family member when: a. An accident involving the resident which results in injury or has the potential for requiring physician intervention . Record review of the facility investigation revealed that on 1/27/25 at approximately 1:35 PM Resident #5 was being assisted from her bed to the wheelchair by two 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 RR 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 X-ray of the right tibia fibula dated 1/28/25 revealed Mildly displaced transverse fracture through the proximal tibial metadiaphysis and a minimally displaced fracture of the fibula head. Record review of a Nursing Note dated 1/29/25 10:01 AM revealed a late entry for 1/27/25 at 1:35 PM indicating that Resident #5 was lowered to the floor during a transfer when her knees became weak, no injuries were noted, and the resident had no complaints. This review revealed no indication that the RR was notified of the incident. An interview with the Administrator (ADM) on 5/1/25 at 8:15 AM revealed that he was not the ADM when the incident occurred with Resident #5 on 1/27/25. He admitted that he had since spoken to the RR regarding the fact that the RN did not notify them of the residents' fall. He confirmed that the RN did not notify the RR following the residents fall, but she should have. Record review of the Resident #5's demographic page revealed the facility admitted the resident on 6/14/24.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47158 Based on staff interviews, record review and facility policy review, the facility failed to protect the resident's right to be free from sexual abuse for one (1) of 20 residents on the Special Care Unit. Resident #56. Resident #56 was found on 4/24/25 at approximately 3:00 PM, by a Certified Nursing Assistant (CNA) with Resident #16 in the bed and on top of her, with his hand inside her incontinence brief, performing jabbing motions. Resident #16 became violent with the staff when they tried to remove him from Resident #16's room where he hit a staff member with his fist. The facility's failure to prevent the sexual abuse of Resident #56 placed Resident #56 and other residents at risk for sexual assault, in a situation that caused and was likely to cause serious injury, serious harm, serious impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 11/05/24 when Resident #16 began to exhibit sexual behaviors towards staff and the facility did not implement interventions to prevent further sexual behaviors. The SA notified the facility's Administrator of the IJ and SQC on 4/30/25 at 1:20 PM and provided the Administrator with the IJ templates. The facility submitted an acceptable Removal Plan on 5/02/25, in which they alleged all corrective actions to remove the IJ and SQC were completed on 5/1/25, and the IJ removed on 5/2/25. The SA validated the Removal Plan on 5/05/25 and determined the IJ and SQC was removed on 5/2/25, prior to exit. Therefore, the scope and severity for 42 CFR: 483.12 (a)(1)- Free from Abuse, Neglect and Exploitation (F600), 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. Cross Reference F609, F656 Findings Include: Record review of the facility policy Abuse and or Suspected Crimes Reporting Under the Elder Justice Act, last reviewed 3/24 revealed, .Sexual abuse includes .sexual assault . It is the policy of [Proper Name of Facility] that all residents will be free from physical, mental, and/or verbal abuse . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. Record review of the Default Flowsheet Data for Resident #56, under Genitourinary on 4/24/25 at 4:13 PM, documented scratches, skin discoloration, and slight edema noted to the labia; maroon/purple and pale overall paleness; maroon/purple bruising noted to the left thigh; maroon/purple bruising with yellow outer edges noted to the left lateral eyebrow; and scratches noted to the left thigh and bilateral outer labia with bruising and redness to both areas. Record review of the Nursing Note for Resident #56, dated 4/29/25, written by Licensed Practical Nurse (LPN) #2 revealed a late entry for 4/24/25 that stated, This nurse alerted by CNA to come to elder's room. When this nurse entered room, observed a male elder on top of this female elder, both were fully clothed, male elder refuses to get off of female elder and required 2 (two) more CNA to assist, male elder becomes violent and punches one of the CNAs in the nose, male elder removed from this elder's room and taken back to his room with supervision. [Proper Name of Administrator] aware . Social Worker (SW) aware and she talked to family, and [Proper Name of Physicians] aware per this nurse . Record review of the Nursing Note for Resident #16, dated 4/24/25, documented that a CNA doing a visual check observed the elder in a female elder's room on top of her. The clothes were intact. When attempts were made to remove this elder, he became violent and punched a CNA in the nose. He was returned to his room, and supervision was provided at his doorway to maintain the female resident's safety. In an interview with CNA #3 on 4/29/25 at 10:45 AM, she stated that on the afternoon of 4/24/25, she came out of another resident's room and heard a commotion. She saw staff going into Resident #56's room, so she followed and saw Resident #16 lying on top of Resident #56. Both residents were fully dressed, and Resident #16 had his hand up Resident #56's pants leg. She said staff were attempting to remove him and he became agitated, hitting a CNA in the face. She stated it took about four staff members to remove him. CNA #3 further stated that Resident #16 frequently makes inappropriate statements about wanting sex and has grabbed CNAs between their legs, but she had never seen him attempt to touch another resident in this way. She said CNAs usually take two people when giving him care and try to discourage his behavior, but that he still grabs staff between their legs. After the incident, he was taken to his room, and the CNAs on duty conducted visual checks, but he was not on 1:1 supervision. At some point, he came out of his room and was in the dining area making sexual statements in front of other residents, so they returned him to his room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the Administrator on 4/29/25 at 12:50 PM, he stated that on 4/24/25 at approximately 3:20 PM, he was notified by LPN #2 that Resident #16 was found on top of Resident #56, and he called for a Registered Nurse (RN) to assess her. He stated that at that time he was not informed that Resident #16 had his hands in Resident #56's brief. He stated that the resident's responsible party was notified by the Social Worker, and the physician was also notified. He verified that he reported the incident online to the Attorney General's Office. The Administrator stated that staff working the unit were instructed to supervise Resident #16 until he was transferred to the geriatric hospital on the afternoon of 4/25/25. He verified that no other residents were assessed for signs of abuse at that time and no other body audits were performed. The Administrator confirmed that this is a memory care unit that both Resident #56 and Resident #16 reside on. In an interview with RN #3 on 4/30/25 at 9:15 AM, she stated that on 4/24/25 around 4:00 PM, she was called to assess Resident #56 after Resident #16 was found on top of her. Resident #56 was noted to have irregularly shaped scratches and bruising on her left thigh, approximately the size of a quarter, bruising to her left eye, and scratches and bruising on both sides of her labia. She stated she notified the Administrator and Social Worker of her finding in the body audit. In an interview with CNA #6, #7, and #8 on 4/30/25 at 10:00 AM, they all stated that Resident #16 has a history of touching and grabbing staff's private parts and making comments like give me that p**** in front of other residents. They stated they had never seen him attempt to touch other residents, but he does touch staff and that he makes inappropriate sexual comments to other residents. They said that after the incident on 04/24/25, while Resident #16 was in the dining area on 4/25/25, he was fondling himself, making sexual gestures at female residents, and making inappropriate sexual statements, after which he was returned to his room. In an interview with LPN #3 on 4/30/25 at 10:15 AM she stated that Resident #16 has always exhibited aggressive verbal sexual behaviors. He makes sexual gestures toward anyone who walks by and says things like I want your p****. She stated he grabs CNAs during Activity of Daily Living (ADL) care and masturbates in common areas. She said that on the morning of 4/25/25, she was instructed to keep him under supervision in the dining room, but he continued to display inappropriate sexual behaviors. Although he was returned to his room, he is ambulatory and would come right back out. She added that he wanders and walks around the unit and, if his roommate is in the bathroom, he will go into other resident's room to use the restroom. In a telephone interview with CNA #2 on 4/30/25 at 2:00 PM, she confirmed that on the afternoon of 4/24/25, she was returning from filling the ice cart and saw Resident #16 on top of Resident #56 with his hand under her pants, fondling her forcefully. She stated that she witnessed Resident #56 lying on her back with her hands shaking and held over her head and face, while Resident #16 held her down forcefully with his left arm. CNA #2 yelled for help, and three other CNAs came. They physically removed Resident #16, who was aggressive, agitated, and combative, hitting and kicking at staff. She stated he hit her, CNA #3, in the face with his fist. After much effort, the staff removed him from Resident #56's bed and returned him to his room for supervision. She described him as violent and said he has always made sexual statements and grabbed staff. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview with LPN #2 on 4/30/25 around 2:30 PM, she stated she was called to Resident #56's room on the afternoon of 4/24/25 and witnessed Resident #16 on top of Resident #56. Both were clothed, and she did not see his hand in her brief. She confirmed Resident #16 had a history of inappropriate sexual verbalizations, but she had not seen him touch other residents. She verified she notified the Administrator. In a telephone interview with the Psychiatric Nurse Practitioner (NP) on 5/1/25 at 10:15 AM, she stated that the staff keep her updated on Resident #16's behaviors and notify her if he has any increases. She verified that Resident #16 had inappropriate sexual behaviors and had an increase of these behaviors in November of last year and at that time his Depakote was increased on 11/4/25. During a further record review of the medical record for Resident#16 the notes below were revealed: Record review of Nursing Note for Resident #16 dated 11/5/24 revealed elder has inappropriate behaviors of groping at staff .sexually inappropriate behaviors, regularly touch his genitalia in public . Record review of Psychiatric Progress Note and Case Conceptualization note for Resident #16 dated 11/7/24 completed by Nurse Practitioner, revealed a diagnosis of Dementia. Review of the Case Conceptualization note revealed His Depakote was recently increased due to increase in inappropriate behaviors Record review of Psychiatric Progress Noted for Resident #16 dated 1/9/25 completed by Nurse Practitioner, revealed Staff reports that patient continues to exhibit inappropriate sexual behaviors . Record review of Social Work note, for Resident #16 dated 2/3/25 revealed Elder made eye contact with the Social Worker and made sexual statements during the interview .According to staff, the resident makes inappropriate sexual comments to staff routinely . Record review of Progress Notes, for Resident #16 dated 2/12/25, and signed by the PTA revealed Pt (patient) stated, 'I'll go for a walk with you if you give me some sugar' Then patient attempted to use his foot to inappropriately touch Licensed Physical Therapy Assistant (LPTA) where he stated give me some p**** . Record review of Progress Notes, for Resident #16 dated 2/17/25, and signed by the Physical Therapy Assistant (PTA) revealed Attempted Physical Therapy Treatment where patient was very inappropriate where he kept attempting to inappropriately touch Licensed Physical Therapy Assistant (LPTA) .patient kept attempting to inappropriately touch LPTA while saying very inappropriate stuff. LPTA discontinued treatment. Nursing staff notified. Record review of Nurses Notes, for Resident #16 dated 2/20/25 revealed .elder stuck his foot between CNA's legs in a sexual manner . Record review of the Nursing Note for Resident #16, dated 4/25/25, revealed that the elder ambulated off the unit with staff times two for transfer to [Proper Name of Facility]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/3/25 for Resident #16 revealed a Brief Interview for Mental Status Score (BIMS) score of 3 indicating severe cognitive impairment. Record review of Psychiatric Progress Note for Resident #16 revealed a diagnosis of Dementia and he was admitted to the facility on [DATE]. Record review of the MDS with an ARD of 2/13/25 for Resident #56 revealed a BIMS score of 7 indicating severe cognitive impairment. Record review of the demographic page for Resident #56 revealed that the facility admitted her on 4/15/21 with diagnosis to include Alzheimer's Disease. Review of the removal plan revealed that the facility took the following actions: Immediate Action started on 4/24/2025 at approximately 2:53 PM: 1. On 04/24/2025 at 2:53 PM, Certified Nursing Assistant (CNA) 1 saw Resident #16 on top of Resident #56. CNA 1 yelled for help. Licensed Practical Nurse (LPN) 1 and CNA 1, CNA 2, and CNA 3 entered the room and removed Resident #16 and took him back to his room where supervision was provided by CNA 2. 2. On 04/24/2025 at 3:05 PM, Licensed Master Social Worker (LMSW) and Nursing Home Administrator (NHA) notified by LPN of the incident. 3. On 4/24/2025 at 3:06 PM, a CNA was stationed outside the door of Resident #16 until transportation arrived to take him to an inpatient geropsychiatric unit. 4. On 4/24/2025 at 3:50 PM, LMSW went to evaluate Resident #16 for mood or behavior changes, and none were noted. 5. On 04/24/2025 at 4:13 PM, Staff Development Specialist (SDS) performed a full body audit on Resident # 56. The findings included red purple bruising with yellow edges noted to left outer eyebrow, scratches, skin discoloration and slight edema noted to exterior labia overall paleness maroon/purple bruising noted to left thigh approximate size of a quarter scratches noted to left thigh and bilateral outer labia with bruising and redness noted to both areas. 6. On 04/24/2025 at 4:21 PM, Nursing Home Medical Staff Director (NHMSD) notified by phone by RN 1 of findings from body audit. No orders received. 7. On 04/24/2025 at 4:28 PM, NHA notified the Ombudsman of the incident. 8. On 04/24/2025 at 5:49 PM, the LMSW notified Resident #56's Responsible Party (RP) of the incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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. 24. No staff, including the Director of Nursing, will be allowed to work until in serviced. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 alleged Immediate Jeopardy was removed as of 5/2/25. Validation: The State Agency (SA) validation of the Removal Plan was made during an on-site survey through record review and interviews on 5/5/25. The SA determined all corrective actions were completed on 5/1/25 by the facility and the IJ was removed on 5/2/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baptist Nursing Home-Calhoun, Inc	152 Burke Calhoun City Road Calhoun City, MS 38916

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)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 47158 Based on record review, staff interviews, and facility policy review, the facility failed to report alleged violations of sexual abuse that occurred within the two (2) hour timeframe to the proper authorities for one (1) of one (1) allegations of sexual abuse. Resident # 56 On 4/24/25 at approximately 3:00 PM, Resident #56 was found by a Certified Nursing Assistant (CNA) with Resident #16 in the bed and on top of her, with his hand inside her incontinence brief, performing jabbing motions. Resident #16 became violent with the staff when they tried to remove him from Resident #16's room where he hit a staff member with his fist. The facility's failure to report sexual abuse of Resident #56 to the proper authorities within prescribed timeframes 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. The SA identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 4/24/25 when Resident #16 was found in the bed and on top of Resident #56, with his hand inside her incontinence brief, performing jabbing motions. The SA notified the facility's Administrator of the IJ and SQC on 4/30/25 at 1:20 PM and provided the Administrator with the IJ templates. The facility submitted an acceptable Removal Plan on 5/02/25, in which they alleged all corrective actions to remove the IJ and SQC were completed on 5/1/25, and the IJ removed on 5/2/25. The SA validated the Removal Plan on 5/5/25 and determined the IJ and SQC was removed on 5/2/25, prior to exit. Therefore, the scope and severity for 42 CFR: 483.12 (c)(1)-Reporting of alleged violations (F609)-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. Cross Reference F600, F656 Findings Include: Record review of the facility policy Abuse and or Suspected Crimes Reporting Under the Elder Justice Act, last reviewed 3/24 revealed Elder Justice Act-refers to Section 1150B of the Social Security Act, as established by section 6703(b)(3) of the Patient Protection and Affordable Care Act of 2010. Section 1150B of the Act requires certain individuals in a federally funded long-term care facility to timely report any reasonable suspicion of a crime committed against a resident of that facility. Those reports must be submitted to at least one law enforcement agency of jurisdiction and the State Survey Agency . Procedure: 1. If the reportable event involves serious bodily injury to a resident receiving care in this facility, the staff member shall report the suspicion immediately, but not later than two (2) hours after forming the suspicion . (continued on next page)

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Baptist Nursing Home-Calhoun, Inc	152 Burke Calhoun City Road Calhoun City, MS 38916

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. Record review of the Default Flowsheet Data for Resident #56 under Genitourinary on 4/24/25 at 4:13 PM documented scratches, skin discoloration, and slight edema noted to the labia; maroon/purple and pale overall paleness; maroon/purple bruising noted to the left thigh; maroon/purple bruising with yellow outer edges noted to the left lateral eyebrow; and scratches noted to the left thigh and bilateral outer labia with bruising and redness to both areas. Record review of the Nursing Note for Resident #56, dated 4/29/25, written by Licensed Practical Nurse (LPN) #2 revealed a late entry for 4/24/25 that stated, This nurse alerted by CNA to come to elder's room. When this nurse entered room, observed a male elder on top of this female elder, both were fully clothed, male elder refuses to get off of female elder and required 2 (two) more CNA to assist, male elder becomes violent and punches one of the CNAs in the nose, male elder removed from this elder's room and taken back to his room with supervision. [Proper Name of Administrator] aware . Social Worker (SW) aware and she talked to family, and [Proper Name of Physicians] aware per this nurse . Record review of the Nursing Note for Resident #16, dated 4/24/25, documented that a CNA doing a visual check observed the elder in a female elder's room on top of her. The clothes were intact. When attempts were made to remove this elder, he became violent and punched a CNA in the nose. He was returned to his room, and supervision was provided at his doorway to maintain the female resident's safety. In an interview with the Administrator on 5/2/25 at 12:50 PM he confirmed that he did not identify this as sexual abuse at first and therefore did not report the incident to the State Department within two (2) hours. He revealed that he thought he had 24 hours to report it, so he called the report in the next day on 4/25/25. He further stated that he did not report the incident to the local police department because he did not see it as a crime. Review of the removal plan revealed that the facility took the following actions: Immediate Action started on 4/24/2025 at approximately 2:53 PM: 1. On 04/24/2025 at 2:53 PM, Certified Nursing Assistant (CNA) 1 saw Resident #16 on top of Resident #56. CNA 1 yelled for help. Licensed Practical Nurse (LPN) 1 and CNA 1, CNA 2, and CNA 3 entered the room and removed Resident #16 and took him back to his room where supervision was provided by CNA 2. 2. On 04/24/2025 at 3:05 PM, Licensed Master Social Worker (LMSW) and Nursing Home Administrator (NHA) notified by LPN of the incident. (continued on next page)

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Baptist Nursing Home-Calhoun, Inc	152 Burke Calhoun City Road Calhoun City, MS 38916

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 quarter scratches noted to left thigh and bilateral outer labia with bruising and redness noted to both areas. 6. On 04/24/2025 at 4:21 PM, Nursing Home Medical Staff Director (NHMSD) notified by phone by RN 1 of findings from body audit. No orders received. 7. On 04/24/2025 at 4:28 PM, NHA notified the Ombudsman of the incident. 8. On 04/24/2025 at 5:49 PM, the LMSW notified the 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. 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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 alleged Immediate Jeopardy was removed as of 5/2/25. Validation: The State Agency (SA) validation of the Removal Plan was made during an on-site review through record review and interviews on 5/5/25. The SA determined all corrective actions were completed on 5/1/25 and the IJ was removed on 5/2/25.

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47158 Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to implement a 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 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. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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 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. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 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. 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. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	22. On 4/30/2025 at 6:00 PM, the Interim Director of Nursing and SDS initiated Abuse training to include types of abuse, prevention and employee responsibilities for reporting suspected abuse for all 129 employees. No staff will be allowed to work until in serviced. 23. On 4/30/2025 at 6:00 PM, the IDON and SDS initiated an in-service for all Nursing Staff on implementing and developing Comprehensive Care Plans to include interventions that address inappropriate sexual behaviors. No staff will be allowed to work until in serviced. 24. No staff, including the Director of Nursing, will be allowed to work until 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 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. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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 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. 46013 (continued on next page)

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	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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #40 Record review of Resident #40's Care Plan revealed that she had Diabetes Mellitus, and the 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 [DATE] with medical diagnoses of Type 2 Diabetes Mellitus with Diabetic Nephropathy. Record review of Resident #40's Section C of the Annual MDS dated [DATE] revealed the BIMS score was 12, indicating the resident has 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 1/2 (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. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. Record review of the Resident #92's demographics revealed the resident was admitted to the facility on [DATE] with medical diagnoses including Metabolic Encephalopathy. Record review of Resident #92's Section C of the Annual MDS dated [DATE] revealed the BIMS score was 11, indicating the resident has a moderate cognitive impairment. 48845 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 indicated the resident had moderate cognitive impairment.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47158 Based on staff interview, record review, and facility policy review the facility failed to ensure a resident was free from accident hazards when the facility failed to ensure staff transferred the resident with the proper assistive devices for one (1) of three (3) residents reviewed for accidents. Resident #5. Findings Include: Record review of the facility policy Falls Management revealed It is the goal of [Proper Name of Facility] to assure that our residents remain free of accident hazards as possible and that each resident receives adequate supervision and assistive devices as needed to prevent accidents. Record review of the facility investigation revealed that on 1/27/25 at approximately 1:35 PM Resident #5 was being assisted from her bed to the wheelchair by two (2) Certified Nursing Assistants (CNA), her legs got weak, and the CNAs assisted her to the floor. She was assisted from the floor without difficulty and the Registered Nurse (RN) assessment revealed no injuries. On 1/28/25 at approximately 4:00 PM, Resident #5 complained of pain to her right leg, the physician was notified, and orders were obtained for a radiographic study. The resident was noted to have bruising and edema to her right leg. Her Responsible Party was notified of the findings, and the resident was transferred to the hospital. Evaluation at the hospital revealed that she had a right tibial plateau fracture. Record review of the Resident #5's History and Physical, dated 1/28/25 for Resident #5 revealed the patient arrived to the hospital after a fall at her nursing home a couple of days ago. She states that she twisted he right knee under her when she fell and had pain. It has continued to swell and have ecchymosis. She finally presented for evaluation today and was found to have a right tibial plateau fracture. She is being admitted for orthopedic evaluation and surgical consideration . Record review of a Nursing Note dated 1/29/25 10:01 AM revealed a late entry for 1/27/25 at 1:35 PM indicating that Resident was lowered to the floor during a transfer when her knees became weak. No injuries were noted, and the resident had no complaints. There was no indication that the Residents responsible party was notified of the incident. Record review of the Encounter Problems (Active) for Resident #5 revealed Problem: Activities of Daily Living (ADLs) (Certified Nursing Assistant Care Plan) revealed I need assistance with my ADLs because of impaired vision, frequent bladder and bowel incontinence, generalized weakness, falls with right hip fracture . Under intervention description Transfers: Extensive assistance two (2) care partners (using rolling walker). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview with CNA #5 on 4/30/25 at 9:00 AM, she stated that she and CNA #4 were assigned to take care of Resident #5 on 1/27/25. She stated that CNA #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. Telephone interview with CNA #4 on 5/2/25 at 12:00 PM, 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 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. Interview with the Administrator (ADM) on 5/1/25 at 8:15 AM, he stated that he was not the ADM when the incident occurred with Resident #5, but that he had since spoken to the resident's Resident Representative (RR). He further stated that he explained to the RR that the cause of the fracture was not due to the RN not notifying him, but that it was caused by the CNAs not transferring the resident correctly. Record review of Resident #5's Demographic Page revealed the facility admitted the resident on 6/14/24.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48845 Based on observation, interview, record review, and facility policy review, the facility failed to ensure food was stored and served under sanitary conditions, when staff failed to remove perishable food items, including milk, from the resident's room in a timely manner. This resulted in the potential for foodborne illness due to prolonged exposure of food to room temperature for one (1) of five (5) days of survey. (Resident #90) Findings include: Review of the facility policy titled, Dietary Services undated, revealed under, Purpose: To prevent contamination of food products and therefore prevent foodborne illness. Additionally revealed under, . VI. Proper Food Handling . P. Foods that have stood for several hours at room temperature cannot be considered safe and free from contamination . An observation on 4/29/25 at 11:08 AM revealed Resident #90's breakfast tray was still in the room located on the bedside table. The tray contained leftover contents of breakfast including half a carton of milk. An interview on 4/30/25 at 11:42 AM with Licensed Practical Nurse (LPN) #3 revealed that the breakfast trays were delivered around 6:30 AM. She explained that Resident #90 usually did not eat his breakfast at that time but ate it later, so they left it for him. She confirmed that leaving the breakfast tray until lunchtime could cause the milk to spoil and could cause Resident #90 to have gastrointestinal upset and illness. Record review of Resident #90's Demographics Record revealed the facility admitted Resident #90 on 2/15/24 with a primary diagnosis of Alzheimer's Dementia. Record review of Resident #90's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/05/25 revealed under section C, a BIMS summary score of 7, which indicated the resident was moderately cognitively impaired.