

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2025
NAME OF PROVIDER OR SUPPLIER Baptist Nursing Home-Calhoun, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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>(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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2025
NAME OF PROVIDER OR SUPPLIER Baptist Nursing Home-Calhoun, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0550</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interviews, staff interviews, record reviews, observations, policy and procedure reviews, local county sheriff's report and interview, and review of the social media video, the facility failed to ensure that the rights of Resident #1 to have respect and dignity were honored when two Certified Nursing Assistants (CNAs) taunted, threatened and abused Resident #1 and posted the videos to social media. Resident #1 was one (1) of three (3) residents that were reviewed for Resident Rights. The evening of 07/22/25 two (2) facility Certified Nursing Assistants (CNA)'s posted a video to social media in which they taunted, threatened and abused Resident #1. The video was seen by the community and the family of the resident. The facility's failure to ensure the right to be treated with dignity placed Resident #1 and other residents at risk in a situation that has caused and is 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 07/22/25. The SA notified the facility's Administrator of the IJ and SQC on 07/29/25 at 3:00 PM and provided the Administrator with the IJ templates. The facility provided an acceptable Removal Plan on 7/29/25, in which the facility alleged all corrective actions were completed to remove the IJ on 7/29/25 and the IJ removed on 7/30/25. The SA determined the IJ was removed on 7/30/25, prior to exit, and the scope and severity for CFR S483.10(a)(1) Resident Rights (F550) was lowered to a D, while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Cross Reference F600 Findings Include: Review of the facility's undated policy titled Your Rights and Protections as a Nursing Home Resident read: What are my rights in a nursing home? As a nursing home resident, you have certain rights and protections under Federal and state law that help ensure you get the care and services you need. You have the right to have your personal information kept private. Be Treated with Respect: You have the right to be treated with dignity and respect, as well as make your own schedule and participate in the activities you choose. Be Free from Abuse and Neglect: You have the right to be free from verbal, sexual, physical, and mental abuse. Record review of the facility policy titled HIPPA Sanctions Policy dated and revised 06/25 revealed, The Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires that covered entities have and apply appropriate sanctions against members of their workforce who fail to comply with privacy policies and procedures of the covered entity, or the requirements of the HIPPA Security Rule. Accordingly, it is the intention of (name of facility) to ensure the confidentiality and integrity of protected health information as required by law and professional ethics. Review of the facility policy titled Photographing, Videotaping, Video imaging and/or Audiotaping Policy last revised 3/23 revealed, .Patient identifiable information is any piece of information which can potentially be used to identify, contact, or locate an individual. This includes demographic information, voice audio, facial images, or any unique characteristic of an individual. Photographic images are considered protected health information and are not limited to images of the face. Additionally, any characteristic that could uniquely identify the individual is protected health information. Purpose: To protect the patient's dignity and comply with federal and state privacy laws. Patient Authorization Required. Patient authorization is obtained prior to all photography. Review of the facility's Employees Handbook page 30 of 43 revealed: .Recording Devices and Cameras Team members are not permitted to use cameras, camera phones, tape recorders, or other recording devices on duty or while on (name of facility) premises conducting official business unless such use has been approved by management. Accordingly, team members are prohibited from secretly recording, videotaping, or taking pictures of others. Such conduct is grounds for disciplinary action up to and including termination of employment. Record review of the facility investigation and observation of the video footage revealed that on 07/23/25 at approximately 6:40 AM the facility Director of Nursing (DON) was notified by a resident of the local community that there was a video of Resident #1 posted on social media the evening of 07/22/25. The DON immediately began investigating the incident and she obtained a copy of the video which identified Resident #1 and two (2) Certified Nursing Assistants (CNA#1) and (CNA #2). The local law enforcement was notified of the incident, and they also began an investigation. The DON obtained handwritten statements from CNA #1 and CNA #2 and determined through investigation that CNA #1 and CNA #2 had posted videos of Resident #1 on social media without the permission of Resident #1 and/or her Responsible Parties (RP's). The video revealed that CNA #1 and CNA #2 were taunting, threatening and teasing Resident #1 while she was lying in bed, which lead to Resident #1</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2025
NAME OF PROVIDER OR SUPPLIER Baptist Nursing Home-Calhoun, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2025
NAME OF PROVIDER OR SUPPLIER Baptist Nursing Home-Calhoun, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, observations, resident interviews, record reviews, policy and procedure reviews, video review, and sheriff's arrest report review, the facility failed to protect Resident #1's right to be free from abuse when staff created a video during care of the resident, of verbal and physical abuse, of the resident and posted it to social media. Resident #1 was one (1) of three (3) residents reviewed for Abuse and Neglect. The evening of 07/22/25 two (2) facility Certified Nursing Assistants (CNA)'s posted a video to social media in which they taunted, threatened and abused Resident #1. The video was seen by the community and the family of the resident. The facility's failure to ensure the right to be free from abuse placed Resident #1 and other residents at risk for abuse and neglect in a situation that has caused and is 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 07/22/25. The SA notified the facility's Administrator of the IJ and SQC on 07/29/25 at 3:00 PM and provided the Administrator with the IJ templates. The facility provided an acceptable Removal Plan on 7/29/25, in which the facility alleged all corrective actions were completed to remove the IJ on 7/29/25 and the IJ removed on 7/30/25. The SA determined the IJ was removed on 7/30/25, prior to exit, and the scope and severity for CFR S483.12(a)(1) Freedom from Abuse, Neglect, and Exploitation F600 was lowered to a D, while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Cross Reference F550 Findings Include: Review of the facility policy titled: Abuse last review/revision 04/25, revealed, .It is the policy of (name of facility) that this facility prohibits mistreatment, neglect, or abuse of residents. The residents must not be subjected to abuse by anyone. The resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion. Major Types of Elder Abuse: Physical Abuse. Exploitation. Psychological Abuse: The infliction of mental anguish, as with insults, swearing, or threats;. Verbal Abuse refers to any oral, written, or gestured language that includes disparaging and derogatory terms to residents. Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment, and deprivation. The term abuse is used in its broadest sense and refers to lack of courtesy, teasing, threatening, or overly vigorous restraint of a resident. Review of the facility policy titled Photographing, Videotaping, Video imaging and/or Audiotaping Policy last revised 3/23 revealed, .Patient identifiable information is any piece of information which can potentially be used to identify, contact, or locate an individual. This includes demographic information, voice audio, facial images, or any unique characteristic of an individual. Photographic images are considered protected health information and are not limited to images of the face. Additionally, any characteristic that could uniquely identify the individual is protected health information. Purpose: To protect the patient's dignity and comply with federal and state privacy laws. Patient Authorization Required. Patient authorization is obtained prior to all photography. Review of the facility's Employees Handbook page 30 of 43 revealed: .Recording Devices and Cameras Team members are not permitted to use cameras, camera phones, tape recorders, or other recording devices on duty or while on (name of facility) premises conducting official business unless such use has been approved by management. Accordingly, team members are prohibited from secretly recording, videotaping, or taking pictures of others. Such conduct is grounds for disciplinary action up to and including termination of employment. Record review of the facility investigation and observation of the video footage revealed that on 07/23/25 at approximately 6:40 AM the facility Director of Nursing (DON) was notified by a resident of the local community that there was a video of Resident #1 posted on social media the evening of 07/22/25. The DON immediately began investigating the incident and she obtained a copy of the video which identified Resident #1 and two (2) Certified Nursing Assistants (CNA#1) and (CNA #2). The local law enforcement was notified of the incident, and they also began an investigation. The DON obtained handwritten statements from CNA #1 and CNA #2 and determined through investigation that CNA #1 and CNA #2 had posted videos of Resident #1 on social media without the permission of Resident #1 and/or her Responsible Parties (RP's). The video revealed that CNA #1 and CNA #2 were taunting, threatening and teasing Resident #1 while she was lying in bed, which lead to Resident #1 becoming agitated and upset. The video revealed that CNA #1 threatened Resident #1 with biting her and that she would be sent to Geri psych. CNA #1 was heard on the video asking Resident #1 if she had ever been bitten and if she did not behave she would bite her. The video showed that CNA #1 slapped the back of Resident #1's upper right arm and</p>		