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 _____	10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 10/24/23-10/26/23. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements of participation related to F585, F656, F677, and F757. The census at the time of the survey was 95 and the facility is licensed for 120.	F 000		
F 585 SS=F	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights	F 585		12/6/23

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

Electronically Signed | 11/16/2023

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 _____	10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 1	F 585		

contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect,

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 _____	10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 2 abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, record review and facility policy review the facility failed to follow up and resolve grievances regarding residents' complaints related to cold food for two (2) of six (6) resident's present during the resident council meeting, Residents #15, and Resident #45, and failed to provide the residents with a way to file a grievance for six (6) of six (6) residents present during the resident council meeting. Residents # 6, Resident #15, Resident	F 585	**Corrective actions accomplished for residents found to have been affected by the deficient practice: Administrator, Director of Nursing and Social held a Resident Council meeting on November 1, 2023 to provide information necessary to voice a complaint or grievance with Resident #6, Resident #15, Resident # 44, Resident # 45, Resident	

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 _____	10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 3 #44, Resident #45, Resident #49, and Resident #71. Findings include: Review of the facility policy titled, "Patient Complaint and Grievance Policy" with a revision date of 01/19 revealed, "Policy ... Patients and/or representatives have the right to voice concerns verbally or in writing when their expectations are not met ...Open communication with patients, visitors, providers, and employees is reinforced with a defined process that includes intake, routing/tracking, investigation, resolution and reporting of patient or patients representative's concerns. Patients and their representatives must be informed of the grievance/complaint process, including who to contact and how to express concerns ...III. Procedure for addressing and resolving Complaints and Grievances ...G. A complaint or grievance is considered resolved when the patient or representative is satisfied with the actions taken on his/her behalf ...The patient or representative is contacted and given the resolutions/actions..." Review of the facility Grievance Log revealed there were no documented grievances since 2015. An interview on 10/25/23 at 8:40 AM, with the Licensed Social Worker (LSW) revealed she has just been handling any issues or grievances as things are brought to her, but not documenting them. She stated that she really hasn't had any issues or grievances come up. She confirmed that she has had several complaints about cold food but does not document what she has done to fix it or if the residents felt like the issue was	F 585	#49 and Resident #71. Resident #15 and #45 were instructed during this meeting to notify staff immediately if food is cold so that it can be replaced. ** Identification of other residents having the potential to be affected by the same deficient practice: All resident who are admitted and presently reside at this facility have the potential to be affected by the deficient practice of failing to follow-up and resolve grievances regarding residents' complaints. **Measures put into place or systemic changes to ensure the deficient practice will not recur: Policy entitled Resident Complaint and Grievance was reviewed by Administrator, Director of Nursing, Quality Control Nurse and Social Worker with revisions made on October 30, 2023 to include the procedure for addressing and resolving complaints and grievances, time frame and documentation. Staff were in-serviced on the revised policy on 11-1-2023, 11-3-2023 and 11-6-2023 Policy signage entitled, "How to Report a Complaint or Grievance" was created and posted at three location in the facility by the Administrator. The north unit, south unit and front entrance now has signage with instructions for filing a voiced or written complaint. A Resident Council meeting was held on November 1, 2023 with both verbal and written explanation	

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 _____	10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 4 resolved. When asked what the purpose of a grievance log was, the LSW responded "that's a good question". An interview on 10/25/23 at 8:55 AM, with the Administrator confirmed that they have not been documenting grievances. She stated that the facility has had some grievances that should have been documented and followed up on. She stated that "it is just like nursing 101, if it is not documented then it wasn't done." She stated the purpose of a grievance log is to monitor and follow up on the grievance to document it has been resolved and we should have a way for the residents to voice a grievance. During the Resident Council Meeting on 10/25/23 at 11:14 AM, the 6 residents that were present revealed they were not aware of how to file a grievance or if the facility had a grievance officer that handles grievances. During the resident council meeting Resident #15 and Resident #45 stated that the food is sometimes cold, and Resident #45 revealed he has complained about that a lot to the kitchen staff and in the Resident Council meetings. Resident #45 revealed no one has ever come to him to tell him what they have done to fix the issue or ask if he felt like it had been resolved. He stated that he had been complaining about the food being cold for a while now but "feels like the left hand doesn't know what the right hand is doing, and it hasn't seemed to get much better." An interview on 10/25/23 at 2:00 PM, with the Administrator confirmed that they should have been documenting grievances, what was done to resolve it and if it was resolved according to the resident and reporting that information back to	F 585	for filing a complaint or grievance given to all residents in attendance. A copy of the procedure for filing a complaint has been mailed to the responsible party of all residents that reside in our facility. A complaint and grievance log will be monitored through our Occurrences, Safety, Claims, Accreditation and Regulatory (OSCAR) reporting system utilized by the Baptist Health Care System. Utilization of the OSCAR system was put into effect on October 30, 2023. **Facility plan to monitor its performance to make sure the solutions are sustained: The corrective action will be monitored by the Quality Assurance(QA) Coordinator completing a verification weekly on Wednesday during the Interdisciplinary care plan meeting. This verification was implemented by the Administrator on November 1, 2023 and will remain a permanent part of our Wednesday Interdisciplinary care plan meeting. The QA Coordinator will monitor this verification form monthly. This Quality Assurance and Performance form has been implemented and will be reviewed on 12-6-2023. This deficiency, the corrective action an any further problems noted will be presented to the QA Committee monthly for five months for review and recommendation as needed.	

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 _____	10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 5 the residents. Record review of Resident #6's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/20/23 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 13 which indicated the resident is cognitively intact. Record review of Resident #15's MDS with an ARD of 09/18/23 revealed under Section C a BIMS score of 15, which indicated the resident is cognitively intact. Record review of Resident #44's MDS with an ARD of 10/09/23 revealed under Section C a BIMS score of 15, which indicated the resident is cognitively intact. Record review of Resident #45's MDS with an ARD of 10/11/23 revealed under Section C a BIMS score of 12, which indicated the resident is cognitively intact. Record review of Resident #49's MDS with an ARD of 09/27/23 revealed under Section C a BIMS score of 05, which indicated the resident is severely cognitively impaired. Record review of Resident #71's MDS with an ARD of 09/07/23 revealed under Section C a BIMS score of 15, which indicated the resident is cognitively intact.	F 585		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		12/6/23

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 _____	10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 6	F 656		

implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

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 _____	10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 7 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review the facility failed to implement a person-centered care plan for a resident to be up in her chair for all meals (Resident #70) and to monitor for side effects of an anti-coagulant (Resident #84) for two (2) of 20 care plans reviewed. Findings include: Resident #70 Record review of Resident #70's Care Plan with an onset date of 08/16/23 revealed, "CNA (Certified Nursing Assistant) Care Plan: I need assistance with my ADLs (Activities of Daily Living) because of impaired cognition, confusion, communication deficits ...limited mobility, non-ambulatory ...Approaches ...Elder/family request to be up in Geri-chair daily for all meals ..." Record review of Resident #70's "Completed Care Task" 10/18/23 - 10/25/23 revealed there were six (6) meals over the last seven (7) days that the resident remained in bed. An observation on 10/24/23 at 11:45 AM revealed Resident #70 lying in bed. An observation on 10/25/23 at 8:30 AM revealed Resident #70 lying in bed.	F 656	**Corrective actions accomplished for resident #70 and resident #84 found to have been affected by the deficient practice: Director of Nursing (DON) reviewed Care Plan with Certified Nurse Aide #2 on 10-25-2023. Resident was transferred by lift to chair and placed in the dining room for the breakfast meal. Resident #84 was assessed by the DON on 10-25-2023 for an adverse reactions to anticoagulant therapy with non being found. **Identification of other residents having the potential to be affected by the same deficient practice: All resident who are admitted and presently reside at this facility have the potential to be affected by the deficient practice of failure to follow the comprehensive care plan. **Measures put into place or systemic changes to ensure the deficient practice will not recur: DON provided education to all nursing staff regarding comprehensive care plan on 11-1-2023, 11-3-2023 and 11-6-2023. Effective November 7, 2023 all nursing staff are required to sign care plan status	

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 _____	10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 8 An interview on 10/25/23 at 12:10 PM, with CNA #2 stated that some residents have it care planned to get up daily, but she is not sure if Resident #70 has that on her care plan or not and confirmed that the resident had not been up today. An interview on 10/25/23 at 4:00 PM, with the Director of Nurses (DON) confirmed that it was documented that Resident #70 had not been assisted by staff to get up for all meals over the last 7 days even though it was in her care plan. She confirmed that the resident's care plan was not followed like it should have been. An interview on 10/25/23 at 4:10 PM, with Licensed Practical Nurse (LPN) #2 revealed that the purpose of a care plan was to provide the staff with guidelines for the resident's care. She confirmed that if the resident had not been up in her chair for every meal, then the resident's care plan had not been implemented. An interview on 10/25/23 at 4:15 PM, with the Administrator confirmed that the purpose of a care plan was to provide the staff with what care was needed to be provided for that resident. Record review of Resident #70's "Face Sheet" revealed the resident was admitted to the facility on 01/15/21 with medical diagnoses that included Unspecified Dementia, unspecified severity with other behavioral disturbances. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/16/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 99, which indicated the resident is severely cognitively	F 656	sheet weekly to ensure knowledge of any changes made to care plan. **Facility plan to monitor its performance to make sure solution are sustained: The corrective action will be monitored by the QA nurse completing "Care Plan Review Audit" weekly. This audit will contain a review of ten percent of the facility residents picked at random. Beginning 11-6-2023 audit will be completed weekly for five months and will be presented at the QA Committee monthly meeting on 12-6-2023. This QA form was implemented by the Administrator on November 6, 2023 and will be evaluated at the next QA meeting to be held on December 6, 2023. This deficiency, the corrective action and any further problems noted will be presented to the QA Committee monthly for five months with review and recommendations as needed.	

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 _____	10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 9	F 656		

impaired and in Section G that the resident is totally dependent and requires two-person assistance for transfers.

Resident #84

Record review of the Care Plan for Resident # 84 revealed, "Anticoagulant Therapy: I take anticoagulants daily"... Also revealed under, "Approaches: Observe for unusual bruising/bleeding, black, tarry stools, dark urine, tinnitus (ASA), abdominal swelling - notify MD of any abnormal findings/complications ...Meds as ordered and monitor for side effects/effectiveness ... Eliquis 5 MG (milligram) tablet - 1 tab (tablet) PO (by mouth) BID (twice daily)..."

Record review of the Medication Administration Record (MAR) for Resident # 84 dated October 2023, revealed there was not a monitoring tool to observe for the side effects of the anticoagulant medication Eliquis.

Record review of Resident #84's Departmental Notes dated 9/25/23 through 10/25/23 revealed there was no documentation related to the monitoring of the resident taking the anticoagulant medication Eliquis.

In an interview with Licensed Practical Nurse (LPN) #2 on 10/26/23 at 9:35 AM, revealed that the care plan was a guideline for resident care. She revealed that the care plan sets goals for the residents and the staff try to ensure the goals are met. She confirmed that Resident #84's care plan

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 _____	10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 10 was not followed for monitoring of anticoagulant side effects. Record review of the Face Sheet for Resident # 84 revealed the resident was admitted to the facility on 2/01/23 with medical diagnosis that included Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, Cachexia, Personal History of Venous Thrombosis and Embolism, Paroxysmal Atrial Fibrillation, Cerebral Infarct and Hemiplegia affecting left nondominant side. Record review of the MDS with an ARD of 10/02/23 revealed under section C, a BIMS score of 9, which indicated Resident # 84 is moderately cognitively impaired. Also revealed under section N, the resident is taking an anticoagulant medication.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, record review and facility policy review the facility failed to get a resident up in her wheelchair for all meals; for a resident that required assistance with their Activities of Daily Living (ADL) for one (1) of 20 resident's reviewed for ADLs. Resident #70 Findings include: Review of the facility policy titled, "Activities of Daily Living" with the last review date of 4/3/18	F 677	** Corrective actions accomplished for resident #70 found to have been affected by the deficient practice: Resident #70 was transferred by lift to her chair and up for the breakfast meal on 10-27-2024. ** Identification of other residents having the potential to be affected by the deficient practice:	12/6/23

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 _____	10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 11 revealed "Policy ... (Proper name of the facility) will provide assistance to residents as necessary and supervise and assess resident function in order to plan care to maintain optimum ADL function as long as possible ..." An observation on 10/24/23 at 9:30 AM, revealed that Resident #70 was lying in bed and had confused responses to an attempted interview. An observation on 10/24/23 at 11:45 AM, revealed Resident #70 was lying in bed and had no response to an attempted interview. An observation and interview on 10/25/23 at 8:30 AM, revealed Resident #70 was lying in bed. Interview on 10/25/23 at 12:10 PM, with Certified Nurse Assistant (CNA) #2 revealed she is the CNA for this resident. She confirmed that the resident cannot get herself out of bed and that staff must use a lift. She confirmed that the resident had not been up today. Interview on 10/25/23 at 4:00 PM, with the Director of Nurses (DON) confirmed that it was documented that the resident had not been gotten up for all meals over the last 7 days even though it was care planned to do so. She stated sometimes the resident refuses, but there is no documentation that the resident had refused. Record review of Resident #70's "Completed Care Task" 10/18/23 - 10/25/23 revealed that there were six (6) meals over the last seven (7) days that the resident remained in bed and was not gotten up to a chair to eat her meal. Review of the Resident #70's October 2023	F 677	All residents who are admitted and presently reside at this facility have the potential to be affected by the deficient practice of failing to provide Activities of Daily Living (ADL)Assistance. **Measures put into place to prevent or systemic changes to ensure the deficient practice will not recur: DON provided in-service educating all Certified Nurse Aides (CNA) regarding ADL assistance for dependent residents on November 1, November 3, and November 6, 2024. Effective November 7, 2023 all CNA's are required to review and sign care plans weekly to ensure knowledge of ADL changes. Licensed Practical Nurse will complete ADL-Staff Assistance monitoring form each shift. **Facility plan to monitor its performance to make sure solutions are sustained: The corrective action will be monitored by the QA nurse completing ADL-Staff Assistance Audit form weekly. This audit will contain a review of ten percent of the facility residents picked at random. Effective 11-6-2023 the audit will be completed weekly for three months and will be presented at the QA Committee monthly meeting. Effective November 6, 2023 Licensed Practical Nurse will complete weekly for three months ADL-Staff Assistance monitoring form on 10% of assigned hallway each shift.	

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 _____	10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 12 Electronic Treatment Administration Record (ETAR) revealed no behavior indicated for the last 7 days that would have prevented the staff from getting her out of the bed to a chair for meals. Record review of Resident #70's "Face Sheet" revealed the resident was admitted to the facility on 01/15/21 with medical diagnoses that included Unspecified Dementia, unspecified severity with other behavioral disturbances. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/16/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 99, which indicated the resident is severely cognitively impaired and in Section G that the resident is totally dependent and requires two-person assistance for transfers.	F 677	This QA form was implemented by the Administrator on November 6, 2023 and will be evaluated for effectiveness at the QA meeting to be held on December 6, 2023. This deficiency, the corrective action and any further problems noted will be presented to the QA Committee monthly for three months with review and recommendations as needed.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757		12/6/23

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 _____	10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 13 §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and facility policy review, the facility failed to monitor a resident on a physician prescribed anticoagulant medication for signs of bruising or bleeding for one (1) of five (5) residents reviewed for unnecessary medication. Resident # 84. Findings include: Record review of the facility policy titled "Medication Administering and Monitoring Policy" with a revision date of 4/23 revealed, " ...20. Monitoring Medication Effects: a. Medication monitoring is a collaborative process including the physicians, nurses, patient, and other health care providers. b. Medication monitoring includes continuous input from various disciplines and the patient. This input includes the patient's perception/concerns or if appropriate, the patient's family, in order to assess, reassess and improve upon the medication regimen .... d. The physician and nurse, along with other disciplines, who administer medication per their respective authorization, monitor the patient's therapeutic response to the medication regimen ..." Record review of Resident # 84's October 2023 Physician Orders revealed an order dated 2/08/23, "Eliquis 5 mg (milligram) tablet -1-tab (tablet) PO (by mouth) BID (twice daily)." The	F 757	**Corrective action accomplished for resident #84 found to be affected by the deficient practice: Resident #84 was assessed by the Director of Nursing on 10-25-2023 for any adverse reactions to anticoagulant therapy. **Identification of other residents having the potential to be affected by the same deficient practice: All residents admitted and presently reside at this facility have the potential to be affected to be affected by the same deficient practice. **Measures put into place or systemic changes to ensure the deficient practice will not recur: The Administrator, Director of Nursing, MDS Coordinator and Quality Nurse reviewed all current residents on October 27, 2023 for anticoagulant use that is not monitored with no other resident affected. A special requirement to monitor for adverse side effects was added to the	

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 _____	10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 14 Physician Orders did not indicate an order to monitor for the side effects of the anticoagulant medication. Record review of the Medication Administration Record (MAR) for Resident # 84 dated October 2023, revealed there was not a monitoring tool to observe for the side effects of the anticoagulant medication Eliquis. An interview on 10/25/23 at 10:03 AM, with Licensed Practical Nurse (LPN)#3 confirmed that Resident # 84 did not have a physician order or a special requirement on the MAR to monitor for the side effects of an anticoagulant medication. She revealed that the medication nurses would be responsible for charting the monitoring and side effects in the nurse's notes. Record review of Resident #84's Departmental Notes dated 9/25/23 through 10/25/23 revealed there was no documentation related to the monitoring of the resident taking the anticoagulant medication Eliquis. An interview on 10/25/23 at 10:40 AM, with the Director of Nursing (DON) confirmed there should be a monitoring tool on Resident #84's MAR for the nurses to document any observed side effects related to the anticoagulant medication. She revealed that they should have something in place to prompt the nurses to monitor for bruising or bleeding. Record review of the Face Sheet for Resident # 84 revealed the resident was admitted to the facility on 2/01/23 with medical diagnosis that included Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, Cachexia, Personal	F 757	emar on 10-25-2023 for all residents that are currently on anticoagulant therapy. QA coordinator in-serviced all nursing staff on this addition to the emar. QA monitoring tool entitled "Anticoagulation Monitoring" was created on October 30, 2023. **Facility plan to monitor its performance to make sure that solutions are sustained: The corrective action will be monitored by the QA Coordinator completing the Anticoagulation Monitoring Form weekly. This audit will be completed weekly for three months and will be presented at the QA monthly meeting. This QA form was implemented by the Administrator on November 6, 2023. This deficiency, the corrective action and any further problems noted will be presented to the QA Committee monthly for three months with review and recommendations as needed. The QA committee will meet December 6, 2023 to review findings.	

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 _____	10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 15 History of Venous Thrombosis and Embolism, Paroxysmal Atrial Fibrillation, Cerebral Infarct and Hemiplegia affecting left nondominant side. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/02/23 revealed under section C, a Brief Interview for Mental Status (BIMS) score of 9, indicating Resident # 84 is moderately cognitively impaired. Also revealed under section N, the resident is taking an anticoagulant medication.	F 757		