Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/30/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST NURSING HOME-CALHOUN, INC	**152 BURKE CALHOUN CITY ROAD , CALHOUN CITY, Mississippi, 38916**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
M0000	Initial Comments On 07/29/25 through 07/30/25 the State Agency (SA) conducted an onsite complaint investigation (CI) for MS #2570227, for the facility self-reported incident of abuse of a resident (Resident #1). The facility reported that two (2) facility Certified Nursing Assistants (CNA)'s had taunted, threatened and abused Resident #1 and had posted a video of the incidents on social media where the video identifying Resident #1 was seen by the community and the family of the resident. The SA determined that the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and deficiencies were cited at M500 Residents Rights. During the investigation of the FRI, the SA identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 07/22/25. The IJ and SQC existed at: Rule 45.17.2 Residents' Rights (M500) Level IV The facility's failure to ensure the right to be free from abuse and 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 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.	M0000		08/12/2025

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

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M0000	Continued from page 1 The SA determined the IJ was removed on 7/30/25, prior to exit, and the scope and severity for Rule 45.17.2 Residents' Rights (M500) Level IV was lowered to a Level II 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. At the time of the complaint investigation, the facility was licensed for 120 beds and the census on was 91.	M0000		
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;	M0500	**Corrective actions accomplished for residents found to have been affected by the deficient practice: Resident #1 had a full body audit on 7/23/25 with no significant findings. Resident #1 received a psychological evaluation by the Nurse Practitioner on 7/28/25 with no significant findings. Certified Nursing Assistant #1 and Certified Nursing Assistant #2 were immediately suspended and terminated on 7/23/25. **Identifications of other residents having the potential to be affected by the same deficient practice: Full body audits were conducted by the Assistant Director of Nursing, Registered Nurses, and the Staff Development Specialist on all residents to verify no injuries suggestive of abuse were present. The audits were completed on 7/29/25. There were no findings suggesting abuse. All cognitive residents under the care of the staff in question were interviewed by the Assistant Director of Nursing and the Staff Development Specialist to ensure that all residents were protected and free of abuse, neglect, and exploitation on 7/23/25. **Measures put into place or systemic changes to ensure the deficient practice will not recur: Abuse training for all staff members to include types	08/21/2025

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M0500	Continued from page 2 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full	M0500	Continued from page 2 of elder abuse, neglect and exploitation; prevention of abuse, neglect and exploitation; employee's responsibilities should abuse be suspected; cell phone usage, vulnerable adults and HIPPA training was completed by the Staff Development Specialist on 7/31/25. Updated Abuse training for all new staff members was initiated by the Human Resources Manager on 8/4/25. An Ad-Hoc Quality Assurance Committee meeting was held on 7/29/25. The committee updated the Quality Assurance Performance Improvement Policy to include emergency meetings to discuss reportable events during the investigational time frame. The policy change was completed on 7/29/25. **Facility's plan to monitor its performance to make sure that solutions are sustained: Five weekly staff audits per hallway will be conducted by Assistant Director of Nursing or the Director of Nursing to monitor resident rooms with doors closed, reason for the door closed, and if any staff members are on their cell phone in the room. The audits were started on 7/30/25 and will be conducted weekly for three months and then monthly for three months. The audit results will be reviewed in the Quality Assurance Performance Improvement meetings starting on 8/20/25. The Quality Assurance Performance Improvement meeting will be monthly for three months, then every two months for six months, and quarterly thereafter. Five supervisory rounds will be performed on five residents by the Assistant Director of Nursing or the Director of Nursing to monitor for any grievances or complaints the resident may have and ensure that no staff member has used their cell phone in the resident's room. The audits were started on 7/30/25 and will be weekly for six months. The audits were started on 7/30/25. The audit results will be reviewed in the Quality Assurance Performance Improvement meetings starting on 8/20/25. The Quality Assurance Performance Improvement meeting will be monthly for three months, then every two months for six months, and quarterly thereafter. Audits of abuse training for new staff members will be	

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M0500	Continued from page 3 recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on staff interviews, observations, resident interviews, record reviews, policy and procedure	M0500	Continued from page 3 conducted by the Human Resources Manager to monitor that all new staff members are trained for abuse, neglect, and exploitation. The audits were started on 8/5/25 and will be monitored monthly for six months by the Human Resources Manager. The audit results will be reviewed in the Quality Assurance Performance Improvement meetings starting on 8/20/25. The Quality Assurance Performance Improvement meeting will be monthly for three months, then every two months for six months, and quarterly thereafter.	

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M0500	Continued from page 4 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 which revealed 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 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 prior to exit, and the scope and severity for Rule 45.17.2 Resident Rights (M500) was lowered from Level IV to a Level II, 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. 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	M0500		

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M0500	Continued from page 5 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).	M0500		

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M0500	Continued from page 6 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 sat on Resident #1's bed on top of her lower legs. Resident #1 could be heard saying that she was hurting her legs and to get off her. During the entire video CNA #2 could be heard laughing. It was determined through the facility investigation that the video of Resident #1 was taken in her room while she was in her bed at a time between 4:30-5:00 PM on 07/22/2025. The investigation revealed that the unauthorized video was posted to the social media platform by the two (2) facility CNA's and was later shared with other employees of the facility and then it eventually was shared with the family members of other residents in the facility. In viewing the video, it was visible that Resident #1 was upset by the abuse and taunting and was heard on the video cussing thetwo CNAs as both were laughing at Resident #1. Record review of the facility's documentation of the incident titled: "Report of Violation Under Mississippi Vulnerable Adult Act" completed and signed by the facility's DON and dated 07/25/25. The report revealed: On July 23, 2025, at approximately 6:40 A.M., a video was received of (CNA #1) assigned to (Resident #1), appearing to upset her. The CNA tapped (Resident #1) on her right arm. The audio is not clear on the video, but laughing can be heard. (CNA #2) admitted during the investigation interview that she was the one that recorded the video. (CNA #2) posted the video on a private story on her (social media) page and tagged approximately six (6) people in it for viewing. (Resident #1) can be seen in the video lying in her bed in (room #). The video was screen recorded by someone and has now spread throughout the community. (Resident #1's) Resident Representative (RR#1) was notified and he voiced that he and his family had plans to come to the facility concerning the matter. (Resident #1's) family arrived at the facility on 07/23/25 at approximately 8:15 A.M. upset and showed staff members a copy of the video on their personal cell phone. The (local county Sheriff's Department) was notified and arrived at the facility to speak with the family and staff members concerning the incident. The two CNAs involved (CNA #1 and CNA#2) were arrested by (local county Sheriff's officer) on July 24, 2025, with	M0500		

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M0500	Continued from page 7 pending charges of abuse. (Resident #1) is an 89-year-old female admitted to (name of facility) on April 27, 2021, per the services of (name of physician) due to dementia with behavioral disturbances. Resident #1 has a BIMS (Brief Interview for Mental Status) score of 3 indicating severe cognitive impairment. She is usually able to make her needs known and she usually understands others. She is non-ambulatory. She uses a staff propelled wheelchair for mobility. She requires two-person extensive assistance with bed mobility, personal hygiene, bathing, and dressing. She's incontinent with bowel and bladder. The report was dated 07/25/25 and signed by the DON. In an interview with the Nursing Home Administrator (NHA) on 07/29/25 at 9:15 AM he confirmed that two (2) facility CNA's (CNA #1 and CNA#2) had been terminated from the facility on 7/23/25 for the abuse of Resident #1. He stated that on 07/22/25 at or around 4:30 PM the two CNA 's video taped Resident #1 during delivery of care in her room and then posted the video to social media on the evening of 07/22/2025. The NHA stated that the county Sheriff arrested the two CNAs and charged them with abuse of a Vulnerable Adult. On 07/29/25 at 9:30 AM in an interview with the DON she confirmed that she obtained hand-written statements from the two (2) CNA's (CNA #1 and CNA #2) and that they had admitted to her through their statements that they did not view their interactions with Resident #1 as abuse. They stated that they were just "playing" with Resident #1 and that they were video taping her for her family to have memories of her. The CNAs stated that they should not have posted the video to social media but had only posted it to their private story and invited six (6) guests to view it. They had not thought that the video would be re-posted by others on various other social media platforms. The DON stated that the county Sheriff had arrested the two CNAs for abuse of a Vulnerable Adult and that they had spent the night in jail. The local news station also reported the incident as abuse of a Vulnerable Adult. The DON stated that the family came to the facility on 07/23/25 at approximately 8:15 AM and they were very upset that the video of Resident #1 was posted on social media the evening of 07/22/2025. The DON first learned about the video and abuse of Resident #1 at approximately 6:40 AM on 07/23/2025. In an interview on 07/29/25 at 10:00 AM with the Assistant Director of Nursing (ADON) it was revealed that she was working on 07/22/2025 and had gone into Resident #1's room around 4:30 PM to talk to CNA #1 about a full-time position at the facility. ADON	M0500		

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M0500	Continued from page 8 stated that she did not see any abuse occurring at that time and had no knowledge of the incident until she was told about it on the next day 07/23/2025. ADON stated that CNA #1 and CNA #2 both had been working at the facility for close to a year and she stated that she hated to think about what occurred to the resident just moments after she left the room from talking to CNA #1 regarding swapping from part time to full time. Observation and interview on 07/29/2025 at 10:15 AM with Resident #1 revealed a bed bound resident lying in her bed, aroused easily when spoken to, but confused. Resident #1 was alert to self and able to answer simple questions. Resident #1 was able to tell surveyor her correct date of birth. Resident was oriented to her name but was not oriented to place and time. Resident #1 presented as having dementia. Interview by telephone on 07/29/2025 at 1:20 PM with Resident Representative (RR#1) revealed that he was contacted on 07/22/2025 at approximately 7:30 PM by his grandson and told that there was a video of Resident #1 posted on social media. RR#1 stated that he had no knowledge of what (proper name of social media) was or how to view it on his cell phone and his grandson sent him the video of Resident #1 being abused by two (2) CNA's. RR#1 stated that this was very upsetting to him and his family. RR#1 stated that RR#2 was most upset about the posting of the video and the abuse of Resident #1. RR#1 stated that he came to the facility on 07/23/2025 to talk to the staff about Resident #1 and to get an explanation as to why this video was posted on social media. RR#1 stated that he received numerous phone calls from all over the community and out of state to tell him that there was a video of Resident #1 posted on social media. RR #1 stated that he felt that Resident #1 had been abused by the two (2) CNAs seen on the video. RR #1 stated that the two (2) CNAs seen on the video with Resident #1 were arrested by the county Sheriff's office for abuse of Resident #1. RR #1 stated that the posting of the video was very embarrassing to his family and to Resident #1. Interview on 07/29/2025 at 1:55 PM with RR#2 revealed that she had worked at the facility for many years and had retired from that facility. RR#2 stated that she had placed Resident #1 at the facility in 2021 because she was of the impression that she would be safe and treated well. RR#2 stated that she was very upset over the abusive way the two CNAs had treated Resident #1 on the video. RR#2 stated that she felt that if they were comfortable enough to record and post videos of abuse of Resident #1, she just wonders how long they have	M0500		

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M0500	Continued from page 9 been doing this and to who else. RR#2 stated that on 07/23/2025 she went to her mother's room to assess her and to look at her legs and feet where the CNA #1 had sat on her. RR#2 stated that Resident #1 had a dark bruise on her right ankle. RR #2 stated that she felt that the bruise was a result of CNA #1 sitting on top of her in her bed as seen on the video. Interview on 07/29/2025 at 2:00 PM with the County Sheriff Deputy that arrested the two (2) CNAs revealed that he arrested CNA #1 and CNA #2 for "simple assault of a Vulnerable Adult." He stated that CNA #1 and CNA #2 had been placed in jail overnight and the next day they posted bail and obtained attorneys. The Deputy Sheriff provided the surveyors with a copy of the Sheriff's report dated 07/24/2025. The Deputy Sheriff confirmed that he obtained written statements from the two (2) CNAs while they were in custody, and it would be shared with the grand jury for criminal charges. The record review of the Minimum Data Set (MDS) dated 06/30/2025 Section C-Cognitive Patterns documented that Resident #1 had a Brief Interview of Mental Status (BIMS) score of 3 which indicated that she was severely cognitively impaired. Section G-Functional Status of the MDS dated 06/30/2025 documented that Resident #1 was a two (2) person assist for Activities of Daily Living (ADL) Assistance. The record review of the handwritten statement of CNA #1 that she gave to the facility DON revealed that CNA #1's written statement was very different from what was viewed on the video and posted on social media. CNA #1's handwritten statement that she gave to the facility's DON and was signed by CNA #1 and dated 7/23/2025 revealed: "On July 22nd appr. 4:30 or no later than I took (name of Resident #1) to put her to bed. She was very combative holding on to the walls I then had to tell her it was time for her to go to bed before the other shift came. I then had to strap her on the lift, and she was refusing She punched me multiple times in doing so I was replying "stop hitting me" and "you have to go to bed" She replied with she is not going to bed. I then got her in her bed, and she was hanging on to the lift so me and (name of another staff) proceeded to remove her hands. I stated multiple times if she didn't stop she was going to hurt herself She was cussing and fighting I was trying to change her when she grabbed me by my hair. I got away from her and proceeded with the care. She then still didn't let me pull off her clothes so I then tricked her into letting me get them off when she realize I was trying to clean her she became combative again I then was changed her in a hurry and I was	M0500		

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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, Mississippi, 38916**

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M0500	Continued from page 10 trying to sit her up in bed when she continued to hit me she stated “Do you wanna fight” I then begin to play with her and gave her a little playful tap on the shoulder after the situation was done She looked at me and said “I love you sister, will you come back to sit with me” I gave her a hug and told her I would see her Friday and that was the last time we talked till I picked up her supper tray and even then we were so nice to each other.” Signed by CNA #1 and dated 07/23/2025 and placed in the DON’s investigation. Record review of the handwritten statement given to the DON by CNA #2 and dated 7/23/2025 revealed: “This is I (name of CNA #2) statement. I take full responsibility for the video that’s been brought to your attention. I made a huge mistake by violating HIPPA but also my resident rights. The video that was seen was a misunderstanding. As we were only playing with her I could see how it looked on the outside. This is something we’re used to. When (name of Resident #1) doesn’t wanna lay down she cusses, throws fits, hits everything. This was something we were used to, so we never really paid any mind. I never charted her bad behavior; I didn’t see it that way because it would only be when it was time to lay down. Then she does have a touch of dementia she didn’t know what she was doing, she just knew she didn’t want to go to bed. But to help night shift we try to lay as many people down before they come in. Just to kind of help. In the video you do hear her cussing (CNA #1) out and hitting her, you do see (CNA #1) messing/playing with her back. This was something they often did. It was never any physical or verbal abuse. We shouldn’t be playing with residents I’m aware. But it was never out of anger or anything. We just got so comfortable with her a grew a tight bond with her. She became one of our favorite residents, which I love them all and I do love my job. I made a very terrible mistake, and I truly am sorry. I am willing to prove and do anything to show whoever that this wasn’t a case of abuse in any type of way. She shouldn’t have been recorded I am aware and own up to my wrongings. But I wouldn’t allow any abuse in my presence. I didn’t look at it being abuse because this something we was so use to happening. It was just a mistake and misunderstanding. Anybody in the facility could tell you we wouldn’t hurt anyone and we love everyone. We did inform a nurse that was their about her hitting and cussing. I am truly sorry for what it looked like but abuse in any way wasn’t the case. The date the video was taking was on July 22nd approx. after 4PM to 5ish.” Handwritten statement signed by CNA #2 and dated 7/23/25 and placed in the DON’s investigation.	M0500		

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M0500	Continued from page 11 Record review of the County Sheriff's Report revealed that on 07/24/2025 CNA #1 and CNA #2 were arrested for Abuse/Neglect of A Vulnerable Adult and Exploitation of Vulnerable Adult. The narrative written on the sheriff's report read: "On July 24, 2025, (name of county Sheriff's office) received a report of a Snapchat video (social media) going around that showed two health care workers assaulting an elderly female at the (name of the facility). In the video, you can see that a health care worker was in the patient's room while the other worker was videoing it. After reviewing the video, it showed that the health care worker hit the female patient. The workers were identified as (CNA #2 and CNA #1). Sheriff's Deputy's interviewed both suspects. Both suspects admitted to the allegations, and both wrote out a statement. Both individuals were arrested and charged." The SA was unable to interview CNA #1 and CNA #2 because both had obtained lawyers and would not speak to us during the time the SA was investigating the abuse case. Review of the Removal Plan revealed that the facility took the following actions: The removal plan below is provided in response to the Immediate Jeopardy (IJ) received on 7/29/2025. The State Agency notified the facility administrator of the IJ on 7/29/2025. Brief Description: On July 22, 2025, at 4:30 PM, the facility failed to prevent staff from exploiting and abusing Resident #1 by allowing staff to record and share video footage on their phones of demeaning, degrading content involving the resident by staff members that were assigned to care for her in the facility. The video was posted to a social media platform where the family saw the video footage of the event. Immediate Action started on July 23, 2025, at approximately 6:40 AM: On 7/23/2025 at 6:37 AM, Director of Nursing (DON) was notified by an external source about a video of Resident #1 was posted on a social media platform. On 7/23/2025 at 6:37 AM, DON notified Nursing Home Administrator (NHA). On 7/23/2025 at 7:18 AM, Assistant Director of Nursing (ADON) received a call from NHA requesting to initiate	M0500		

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M0500	Continued from page 12 reporting. On 7/23/2025 at 7:49 AM, ADON spoke with DON to discuss the process of reporting to State and Attorney General (AG). On 07/23/2025 at 8:08 AM, ADON reported the incident to MS Department of Health. On 7/23/2025 at 8:18 AM, ADON reported the incident to the Attorney General. On 7/23/2025 at 8:18 AM, ADON notified Responsible Party (RP). On 7/23/2025 at 8:30 AM, ADON and Staff Development Specialist (SDS) performed full body assessment of Resident #1. The findings were this nurse performed a full body audit that was completed per protocol. Elder's skin assessed from head to toe, including behind the ears, under the breast, axillae, abdomen, groin, back and all extremities. No bruising or lacerations noted. Elder has no wounds. Elder's skin is warm, dry and intact. Elder is alert to self only and talkative. Word salad noted. Elder tolerated assessment without distress. On 7/23/2025 at 8:45 AM, SDS continued to complete full body assessments and interviews of all residents under the care of the staff in question. No negative assessments or outcomes were found. On 7/23/2025 at 9:00 AM, Resident #1's family arrived at facility and met with ADON, Risk Manager (RM), Human Resources Manager (HRM), Licensed Social Worker (LSW), and Head Nurse (HN). On 7/23/2025 at 9:05 AM, Police Department notified. On 7/23/2025 at 9:35 AM, Chief of Police arrived at facility. On 7/23/2025 at 10:03 AM, ADON notified Ombudsmen. On 7/23/2025 at 10:49 AM, ADON notified Primary Care Provider (PCP). On 7/23/2025 at 2:30 PM, LSW discussed with Ombudsmen. On 7/23/2025 at 3:07 PM, Certified Nursing Assistant (CNA) #1 suspended and terminated on 7/23/2025. On 7/23/2025 at 3:47 PM, CNA #2 suspended and terminated on 7/23/2025.	M0500		

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M0500	Continued from page 13 On 7/23/2025 at 4:30 PM, SDS began in-services on HIPAA, Reporting Abuse, Cell phone usage, and Vulnerable Adult Policy until 100% is completed. No staff will be allowed to work until in serviced. On 7/28/2025 at 9:30 AM, Psychiatric Mental Health Nurse Practitioner (PMHNP) evaluated Resident #1 for psychosocial harm. No issues were identified. On 7/29/2025 at 4:20 PM, an emergency QAPI meeting was held to review the immediate jeopardy related to Residents Rights and Abuse and exploitation and review policies and procedures for changes. Attendees were NHA, Nursing Home Medical Staff Director (NHMSD), DON, ADON, Quality Improvement Officer (QIO), Care Plan Nurse (CPN), SDS, HRM, and RM. Policies were reviewed and changes were made to the Quality Assurance and Performance Improvement Policy. The policy update included holding emergency meetings to discuss reportable events during the investigation time frame. The facility alleged that all corrective actions were completed on 7/29/2025, and the IJ removed as of 7/30/2025. The State Agency (SA) validation of the Removal Plan was made on 7/30/25 through interviews, observations, record reviews, and policy and procedure reviews. The SA determined all corrective actions were completed on 7/29/25 by the facility and the IJ was removed on 7/30/25.	M0500		