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 **08/25/2025**

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 The State Agency (SA) conducted a Complaint Investigation (CI), MS #2597732, at the facility on 08/25/25. MS #2597732 was investigated for physical environment and the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged and Infirm, state licensure requirements and cited M1570. The facility held a license for 120 beds, with a census of 93.	M0000		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Pattern	M1570		

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

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M1570	Continued from page 1 Based on observations, interviews, record reviews and policy and procedure reviews the facility did not follow established infection control procedures for the transportation, handling, and disturbing of dirty and clean linens. The facility used the public laundry and transported the dirty and clean linens in the facility van that was for resident use without cleaning the van/bus before and after each use. The facility also used public washing machines without cleaning them before and after each use and for not using hot water temperatures in accordance with infection control policies and procedures. The deficient practice had the potential to affect 93 of 93 residents living in the facility and all staff. Findings Include: The facility policy titled: “Laundry Services” undated, read: “To assure a clean supply of linens and to protect employees who handle and process the laundry.” Soiled linen should be handled as little as possible and with a minimum of agitation to prevent gross microbial contamination of the air and of persons handling the linen. All linens should be stored and transported in carts used exclusively for this purpose, or in linen carts that have been decontaminated after being used for soiled laundry. Dirty linen should be clearly separated from areas where clean linen is handled. Linens should be washed with a detergent in water hotter than 160 degrees Fahrenheit (F) for 25 minutes since this is an effective method for cleaning and for killing most vegetative bacteria. Observation and interview on 08/25/25 at 11:45 AM with the Director of Nursing (DON) confirmed that the facility laundry department had three (3) broken washing machines. DON toured the facility laundry with the State Agency (SA) and stated that they had been transporting the facility laundry to the public laundry facility in the local town. The laundry staff were placing the dirty facility linens in the facility’s resident transport van/bus and taking the linens to be washed and dried and transported back to the facility in the resident transport van/bus. DON stated that there were three (3) commercial “high temperature” washing machines located in the facility laundry and that all three (3) were broken. The DON confirmed that the nursing home facility was located next to the community hospital and Emergency Room (ER) and there was only one laundry department that the hospital and the nursing home shared. The three (3) commercial washing machines were used to wash all the linens for the nursing home, the community hospital, and the ER.	M1570		

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M1570	Continued from page 2 Therefore, since all three (3) commercial washers were broken and un-usable the laundry staff have to transport the linens for all the nursing home, the community hospital and the ER to the local public laundry facility for washing and drying. DON stated that the maintenance department had attempted to repair the washing machines, but the correct parts had not been obtained to do the repairs. Observation was made in the laundry area that there were three (3) commercial “high temperature” washing machines that had signs attached to all three (3) “Out of Order.” The DON stated that the commercial washing machines were over 30 years old and probably needed to be replaced. DON stated that to her knowledge the facility had been using the local public laundry facility for washing the facility’s linens for approximately two (2) weeks.On 08/25/25 at 12:00 PM an interview with the Maintenance Director revealed that the facility had no way of repairing the washing machines without the proper parts and that the parts were ordered and the wrong part was sent, and they had to re-order and he had no timeframe of when the repairs would be completed. Maintenance Director confirmed that all three washing machines were broken down and unusable and stated, “I don’t know how it happened, probably because they are worn out.” Interview on 08/25/25 at 12:40 PM with Licensed Practical Nurse (LPN) #1 confirmed that Resident #1 was on contact isolation because of Extended-spectrum Beta-Lactamase (ESBL) which required contact isolation. LPN #1 confirmed that Resident #1 had to have all linens and personal clothing placed in red bags for infectious waste and washed separately from all other residents' linens and clothing. Interview on 08/25/25 at 1:00 PM with Registered Nurse (RN) #2 revealed that Resident #3 was on contact precaution due to Carbapenem-resistant Pseudomonas aerogenesis (CRPA) of the urine. Record review of the facility roster matrix dated 08/25/2025 revealed that two (2) residents, Resident #1 and Resident #3, were documented as being placed on Transmission-Based Precautions (TBP). Interview on 08/25/25 at 1:15 PM with the Laundry Director revealed that she has been loading the linens into the facility’s resident transport van/bus and transporting the dirty linens to the public laundry facility and washing them in the public washing machines and dryers and transporting them back to the facility. She sorts the laundry in the facility laundry department and places the dirty towels and bed linens inside of plastic bags and then puts them in the van and drives the dirty linen to the public laundry facility. She confirmed that she does not disinfect the van/bus and does not place any type of barrier down inside of the van/bus when transporting the dirty linens or the clean	M1570		

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M1570	Continued from page 3 linens. Laundry Director confirmed that she does not disinfect the public washing machines prior to use and does not disinfect after use and had no way to monitor the temperature to ensure that the washer water temperature had to reach a minimum of 160-degree F in order for the detergent to break down and sanitize the linens. Laundry Director stated that the first facility commercial “high temperature” washing machine had been broken for approximately three (3) weeks and then approximately two (2) weeks ago the second and third facility high temperature commercial washing machines broke down, leaving them without washing machines. Laundry Director stated that all resident clothes and all red bags were washed in the facility in the small “household” washing machine and those were not taken to the public facility. Laundry Director stated that the small “household” washing machine located in the facility laundry department had no temperature gages and she had never used a thermometer to take the hot water temperature.	M1570		