

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A233		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/19/2026	
NAME OF PROVIDER OR SUPPLIER BAPTIST NURSING HOME-CALHOUN, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted six (6) Complaint Investigations (CI MS #3040024, CI MS #3063332, CI MS #3063355, CI MS #3109596, CI MS #3158751 and CI MS #3160082) at the facility from 08/17/2026 through 08/19/2026. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. An extended survey was completed and the SA cited F686 at scope and severity level G for CI MS #3158751 and CI MS #3160082. Based on the facility implementation of corrective actions on 08/10/2026, the SA determined this to be Past Non-Compliance (PNC) and facility was in compliance as of 08/15/2026, prior to the SA entrance on 8/17/2026 for F686. The SA also cited F867 and F842 for CI MS #3158751 and CI MS #3160082. The SA cited F550 for CI MS # 3109596. There were no citations related to CI MS #3040024, CI MS #3063355, and CI MS #3963332. At the time of the survey, the facility was licensed for 120 beds and had a census of 96 at the time of the survey.			F0000			
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			F0686	"Past Noncompliance - no plan of correction required"		

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 reverse for further 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
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F0686 SS = G	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on staff and resident interviews, record reviews and facility policy review, the facility failed to provide treatment and services to prevent pressure ulcers for one (1) of four (4) residents reviewed for pressure ulcers. Resident #1. The facility failed to provide treatment and services to prevent pressure ulcers, specifically routine skin audits and documentation. Resident #1 acquired a pressure ulcer that was not identified until it progressed to a Stage 4 requiring treatment and antibiotics. The wound was discovered by a family member and brought to the facility's attention on 8/10/2026. Based on the facility implementation of corrective actions on 08/10/2026, the SA determined this to be Past Non-Compliance (PNC) and facility was in compliance as of 08/15/2026, prior to the SA entrance on 8/17/2026. Findings Include: A review of the facility's policy, titled "Skin Care: Assessment and Prevention Policy," last revision 10/2025, revealed "...Policy: It is the policy of [Proper Name of Facility] to provide an interdisciplinary, standardized approach to the assessment of skin, prevention of breakdown and management of wounds...2. Skin Inspection-...The Registered Nurse (RN) Supervisor will perform weekly skin inspections according to the weekly skin assessment schedule..." A record review of the facility's investigation revealed on 8/10/26 at approximately 3:00 PM, Resident #1's Resident Representative (RR) called staff to her room reporting that the resident had blood on her pants. The Nurse Manager and Wound Care Nurse (WCN) assessed Resident #1 and she was noted to have a four (4) centimeter (cm) width by 4 cm length by two (2) cm depth Stage IV pressure ulcer to her right posterior hip area with 50% (percent) eschar, 25% granulation, 25% slough, and a moderate amount of serosanguineous drainage with a foul odor. Her primary care physician was notified, and new orders were received related to wound care. New orders were received for Levaquin 500 mg (milligrams) daily for seven (7) days for infection to the wound. The facility identified that the body audit documented on 8/7/26 by Nurse Manager (NM) #1 revealed a skin audit completed on 8/7/26 with no significant findings and intact skin. The Nurse Manager responsible for			F0686			

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F0686 SS = G	Continued from page 2 completing this assessment was suspended on 8/11/26 pending termination following the completion of the investigation. Record review of the wound assessment for Resident #1, dated 8/10/26, revealed Stage IV pressure wound that was described with having "eschar, exposed fat layer, granulation, moist, reddened, sloughing" that was measured to be (length) 4 cm x (width) 4 cm x (depth) 2 cm, with wound bed with 50% eschar, 25% slough, 25% granulation with moderate serosanguineous drainage with foul odor. Peri wound noted to have erythema. Record review of Medication Administration Record (MAR) revealed an order for "Levaquin 500 mg by mouth nightly" for 7 days was started on 8/10/26. Record review of the Advanced Wound Care assessment for Resident #1, dated 8/17/26, revealed Stage IV pressure injury-necrotic tissue flap is over a portion of wound and removed with debridement. Measurements of wound 3.5 cm length by 4.6 cm width, 3.5 cm depth with yellow slough and a large amount of foul yellow drainage noted. During an interview with the Administrator on 8/17/2026 at 10:30 AM, he verified that the Root Cause Analysis (RCA) was that the Nurse Manager #1 failed to do a complete an accurate skin assessment on 8/7/26 but documented "no changes" in Resident #1's skin. In an interview with the Director of Nursing (DON) on 8/17/26 at 10:30 AM, she explained that the Nurse Managers were responsible for completing weekly body audits on all residents on their unit. She verified that the pressure ulcer to Resident #1's right hip should have been identified prior to it reaching a Stage 4 and requiring antibiotics. During an interview with Resident #1 on 8/17/26 at 10:45 AM, she stated that the staff only perform skin audits on her feet. She denied that they had attempted to look at any other areas of her body. She verified that she had a wound to her right hip area but was unsure how long it had been there. A telephone interview with Nurse Manager #1 on 08/17/2026 at 11:56 AM, she verified that she			F0686			

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F0686 SS = G	Continued from page 3 charted "No changes" on the 8/7/26 weekly body audit. She further verified that the resident was standing in the bathroom at the time of the body audit, and she could not see the right side of the resident's body, so she did not assess it. In an interview with Resident #1's RR on 8/18/26 at 10:30 AM, she shared that on 8/1/26 while picking up Resident #1's laundry she noticed blood on the resident's pants. At that time the resident told her it was from going to the bathroom and the RR was initially concerned about the resident having a urinary tract infection (UTI), but she did not. She further revealed that the following week, on 8/10/26, when she picked up Resident #1's laundry she noticed blood again on her pants as well as on her bed sheets. She called staff to the room and upon looking at her skin they found a wound on the resident's right hip that was dark in color. The facility was unsure how long the wound had been there. Record review of the face sheet revealed that the facility admitted Resident #1 on 01/26/23 with diagnosis that included Congestive Heart Failure (CHF). Record review of the Minimum Data Set Assessment (MDS) with an Assesment Reference Date (ARD) of 6/18/2026 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating that Resident #1 was cognitively intact. The facility implemented the following Corrective Action Plan prior to the State Agency's entrance on 8/17/26: On 08/10/2026 at 3:05 PM, the Wound Certified Licensed Practical Nurse (WCLPN) and Registered Nurse Manager (RNM) #1 went to Resident #1 room at the request of the Resident Representative (RR). RNM #1 accessed Resident #1 skin for sources of blood found on the resident's clothing. RNM #1 discovered a Stage 4 pressure ulcer on the resident's right hip. On 08/10/2026 at 3:26 PM, RNM #1 measured the pressure ulcer to be 4-centimeter (cm) x 4 cm x 2 cm and treatment order was received from Nursing Home Medical Staff Director (NHMSD) for Xeroform dressing to be changed daily and monitored for			F0686			

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F0686 SS = G	Continued from page 4 signs and symptoms of infection. WCLPN initiated the treatment. On 08/10/2026 at 3:30 PM, WCLPN notified the Director of Nursing (DON) of the findings on Resident #1. On 08/10/2026 at 3:35 PM, WCLPN called NMMC Wound Center and Hyperbarics and scheduled an appointment for Resident #1 on 08/17/2026 at 12:45 PM and RR was made aware of the appointment. On 08/10/2026 at 3:40 PM, DON notified the NHA of the findings on Resident #1. On 08/10/2026 at 3:45 PM, DON instructed RNM #1 to perform body audits on all residents on the North Nursing Unit. On 08/10/2026 at 4:00 PM, Resident # 1's care plan was updated by Care Plan Licensed Practical Nurse (CPLPN). On 08/10/2026 at 4:30 PM, DON notified the State Agency of the incident by telephone. On 08/10/2026 at 4:35 PM, DON notified the Attorney General's Office of the incident. On 08/10/2026 at 5:00 PM, NHMSD initiated Levaquin 500 milligram (mg) by mouth daily for 7 days and the RR was notified of the new order by WCLPN. On 08/11/2026 at 6:00 AM, Staff Development Specialist (SDS) initiated staff training for Registered Nursing (RN) and Licensed Practical Nursing (LPN) staff members on timely and accurate documentation and the reinforcement of expectations for comprehensive weekly body audits, and no RN or LPN will be allowed to work until in serviced. On 08/11/2026 at 11:04 AM, DON instructed RNM #1, RNM #2, and Registered Head Nurse (RHN) to perform body audits on all residents on the North Nursing Unit. On 08/11/2026 at 2:50 PM, DON and Human Resources Representative (HRR) placed RNM #1 on an investigatory suspension. Initial process for termination started for RNM #1. On 08/11/2026 at 3:41 PM, Registered Dietitian (RD) consulted Resident #1 addressing dietary needs. Physician orders received for Vitamin C daily for 30 days and Zinc twice daily for 14 days.			F0686			

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F0686 SS = G	Continued from page 5 On 08/12/2026 at 3:30 PM, 46 body audits were completed on all residents on the North Nursing Station with no new findings. On 8/14/2026 at 1:32 PM, order was placed by WCLPN for a pressure relieving air flow mattress for Resident #1. Mattress was inflated and placed on bed. On 8/14/2026 at 3:00 PM, Ad hoc Quality Assurance (QA) meeting was held to review the deficient practice that led to the development of a pressure ulcer on Resident #1. A Root Cause Analysis (RCA) indicated the event was associated with the failure to consistently perform and document comprehensive body audits with an opportunity for improved documentation practices and staff accountability. The Skin Care Assessment and Prevention Policy and the Resident Rights Policy were reviewed and no revisions were recommended. Attendees were the NHA, NHMSD, DON, ADON, WCLPN, RNM 2, SDS, RD, HRR, Performance Improvement Coordinator LPN (PICLPN), Restorative Licensed Practical Nurse (RLPN), Infection Control Nurse Manager (ICNM), and Risk Manager (RM). On 08/14/2026 at 4:00 PM, a QA monitoring tool was created to ensure compliance and accuracy of body audits. The DON or the Assistant Director of Nursing (ADON) will conduct random body audits on two residents per hallway per week for a total of 10 residents. These audits will be compared to the previous skin audit conducted by Registered Nursing staff members. This monitor will assess compliance with skin assessment procedures through the audits for the next three months and will be reported in monthly QAPI meetings starting with the August meeting. On 08/14/2026 at 4:25 PM, DON sent an email reporting the incident to the State Agency via email. On 08/14/2026 at 4:37 PM, DON sent an email reporting the incident to the Ombudsman. Validation: The State Agency (SA) validation of the corrective actions was made on-site during the Complaint Investigation through record review and interviews on 8/17/26 through 8/19/26. The SA determined all corrective actions were completed on 8/14/2026 and the facility was in compliance on 8/15/2026 prior to			F0686			

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F0686 SS = G	Continued from page 6 the SA entrance on 8/17/26.	F0686					
F0867 SS = F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track	F0867					

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F0867 SS = F	Continued from page 7 performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance.	F0867					

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F0867 SS = F	Continued from page 8 §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews, record review, review of Quality Assurance and Performance Improvement (QAPI) documentation, facility investigation review, and facility policy review, the facility failed to measure the success of corrective actions and track performance to ensure improvements were sustained when the QAPI Committee failed to review monitoring required by a previous Plan of Correction involving unauthorized photographs or video recordings of residents during two (2) of four (4) quarterly QAPI meetings reviewed. The deficient practice had the potential to affect all 96 residents residing in the facility. Findings included: Record review of the facility policy, "Quality Assurance and Performance Improvement (QAPI)" revealed, "Purpose...Feedback, Data Systems and Monitoring: [Proper Name of Facility] will put in place systems to monitor care and services, drawing data from multiple sources. Feedback systems will actively incorporate input from staff, elders, families and others who are appropriated. It will use performance indicators to monitor a wide range of care process and reviewing the findings against benchmarks and goals set by the facility. The QAPI team at [Proper Name of Facility] will decide what date to monitor routinely..." A review of the facility's Plan of Correction from a previous survey finding on 7/30/25, involving unauthorized photographs/video recordings of residents, revealed the facility implemented monitoring activities to ensure corrective actions were sustained. The Plan of Correction required			F0867			

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F0867 SS = F	Continued from page 9 audits related to staff cellular telephone use, resident grievances/complaints, and abuse training. The facility's Plan of Correction specified that audit results would be reviewed through QAPI. QAPI meetings were to occur monthly for three months, every two months for six months, and quarterly thereafter. A review of the facility's QAPI documentation from August 2025 through July 2026 revealed the facility initially reviewed the required monitoring through QAPI; however, the QAPI documentation for the April 2026 and July 2026 months of the monitoring period did not contain evidence that the required audit results were reviewed by the QAPI Committee. During an interview with the Quality Improvement Nurse (QIN) on 8/19/26 at 10:00 AM, she verified the QAPI meeting minutes for the April 2026 and July 2026 did not document review of the audits required by the previous Plan of Correction. She further verified that the facility had no additional monitoring or auditing process in place to ensure the corrective actions related to unauthorized photographs/video recordings, and resident privacy remained effective and sustained after the monitoring process was discontinued. A review of the facility's current investigations involving Resident #3 and Resident #4 revealed the same type of deficient practice subsequently recurred when staff again used personal cellular telephones to photograph and/or video record residents. The facility's investigation determined the facility failed to protect residents' rights to privacy and confidentiality.	F0867			
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F0550			

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F0550 SS = D	Continued from page 10 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on staff and resident interviews, facility investigation review and facility policy review, the facility failed to ensure residents' rights to privacy and confidentiality were protected for two (2) of six (6) residents reviewed for Resident's Rights. Resident # 3 and Resident #4 Findings included: Review of the facility's policy titled "Your Rights and Protections as a Nursing Home Resident" revealed, "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..." Review of the facility policy titled "Wireless/Cellular Telephones: Use and Management Policy", revealed "Policy: [Proper name of facility] encourages it's employees to use wireless/cellular phones in an			F0550			

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NAME OF PROVIDER OR SUPPLIER BAPTIST NURSING HOME-CALHOUN, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 152 BURKE CALHOUN CITY ROAD , CALHOUN CITY, Mississippi, 38916			
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F0550 SS = D	Continued from page 11 appropriate and safe manner...Guidelines: D. Employees are not permitted to use a camera, including one built into a wireless/cellular phone to take any photograph within a facility..." Review of the facility's "Employees Handbook" page 31 of 44 revealed: "...Recording Devices and Cameras," revealed, "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..." A review of the facility's investigation revealed that on 07/22/26, at approximately 6:30 PM, the Nursing Home Administrator was notified that Human Resources had received a complaint alleging two Certified Nursing Assistants (CNA) recorded a resident using a cellular telephone. The investigation identified that CNA #2 used CNA #1's personal cellular telephone to record Resident #4. CNA #1 reported the recording remained on her personal telephone until she returned home later that evening and deleted it. CNA #1 further reported that her boyfriend at the time may have viewed the recording before she deleted it. Further review of the facility investigation revealed CNA #2 disclosed that, within approximately the previous two months, she had also taken a photograph of Resident #3 holding a baby doll because she wanted the photograph "for memories" and thought it was "cute." A record review of a written statement dated 07/22/26 and signed by CNA #1 revealed that she documented that Resident #4 was sitting in a recliner when CNA #2 used CNA #1's telephone camera to make the video. CNA #1 documented that the video showed Resident #4's face and that Resident #4 was talking and laughing. CNA #1 further documented that her boyfriend may have seen the video before she deleted it from her telephone. A record review of a written statement dated 07/22/26 and signed by CNA #2 revealed that she had documented that she had possessed a recording of Resident #3 kissing her baby doll. An interview with the Administrator and Director of	F0550					

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F0550 SS = D	Continued from page 12 Nursing (DON) on 08/18/26 at 1:30 PM, revealed they verified the facility's investigation determined the facility failed to protect residents' rights to privacy and confidentiality when the CNAs took photographs and video recordings of residents. Record review of the face sheet revealed that the facility admitted Resident #3 on 9/23/22 with diagnosis of Unspecified Dementia. Record Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/28/26 revealed a Brief Interview for Mental Status (BIMS) score of six (6) which indicated severely impaired cognition. Record review of the face sheet revealed that the facility admitted Resident #4 on 3/1/24 with diagnosis of chronic kidney disease. Record Review of the MDS, with an ARD of 7/27/26 revealed a BIMS score of 15 which revealed that the resident is cognitively intact.	F0550			
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F0842			

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F0842 SS = D	Continued from page 13 §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and	F0842					

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F0842 SS = D	Continued from page 14 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interviews, and record review, the facility failed to ensure clinical records were complete and accurately documented for two (2) of five (5) residents reviewed for clinical record accuracy. Resident #1 and Resident #2 Findings included: Record review of a statement on company letterhead, signed by the Administrator and dated 8/19/26, revealed that the facility did not have a policy regarding accurate documentation. Resident #1 A record review of the facility's investigation revealed on 8/10/26 at approximately 3:00 PM Resident #1's Resident Representative (RR) called staff to her room reporting that the resident had blood on her pants. The Nurse Manager and Wound Care Nurse (WCN) assessed Resident #1 and she was noted to have a four (4)-centimeter (cm) width by 4 cm length x two (2) cm depth Stage IV pressure ulcer to her right posterior hip area with 50% (percent) eschar, 25% granulation, 25% slough, and a moderate amount of serosanguineous drainage with a foul odor. The facility identified that the body audit documented on 8/7/26 by Nurse Manager (NM) #1 was not completed in its entirety despite documentation indicating completion. The skin audit completed on 8/7/26 documented no significant findings and intact skin. In an interview with the Administrator on 08/17/2026 at 10:31 AM, he verified that the Root Cause Analysis (RCA) was that the Nurse Manager #1 failed to do a complete an accurate skin assessment on 08/07/2026 but documented "no changes" in Resident #1's skin. He further agreed that the documentation was not accurate. On 8/17/26 at 10:31 AM during an interview with the Director of Nursing (DON), she explained that the Nurse Managers were responsible for completing weekly body audits on all residents on their unit. In a telephone interview with Nurse Manager #1 on 08/17/2026 at 11:57 AM, she verified that she charted "No changes" on the 8/7/26 weekly body			F0842			

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F0842 SS = D	Continued from page 15 audit but the resident was standing in the bathroom at the time of the body audit, and she could not see the right side of the resident's body, so she did not assess it. She agreed that this documentation was not accurate as she had not assessed the resident's entire body. Record review of the face sheet revealed that the facility admitted Resident #1 on 01/26/2023 with diagnosis that included Congestive Heart Failure (CHF). Record review of the Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 6/18/2026 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating that Resident #1 was cognitively intact. Resident #2 Observation and interview of Resident #2 on 8/17/26 at 10:51 AM, revealed an intact dressing to his left wrist area dated 8/15/26. The dressing was noted to have a moderate amount of light greenish drainage outlined on the dressing. Continued observation of Resident #2 revealed a non-intact dressing on his left outer leg, also dated 8/15/26. Resident #2 shared that his dressings are supposed to be changed every day, but they did not do it yesterday because they changed nurses. Record review of the "Medication Administration History" dated 8/1/26 through 8/18/26, for Resident #2 revealed an order for an abrasion to left lower extremity (LLE), clean with wound cleanser, pat dry, apply Aquacel AG and cover with a dry dressing daily as well as an order for treatment to left forearm (LFA), clean weeping areas with wound cleanser, pat dry, cover with Aquacel AG, wrap with gauze daily. In a telephone interview with LPN #1, on 8/19/2026 at 9:03 AM, she verified that when signing off the medications she had given, she also signed off the treatment although she had not done it. She stated she had intended to go back and change the dressing but forgot. She agreed that treatments should not be signed off until they are completed and this constitutes inaccurate documentation. In an interview and further review of the "Medication Administration History" with Licensed Practical Nurse (LPN) #1 on 8/17/2026 at 10:58 AM, she verified that documentation on 8/16/26 revealed that the treatment was performed and confirmed that she had not completed the wound care. She confirmed that not performing wound care as ordered could			F0842			

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F0842 SS = D	Continued from page 16 cause a wound infection or worsening of the wound. An interview with the Director of Nursing (DON) on 8/97/26 at 9:05 AM, she verified that the documentation was not accurate and it was her expectation that the nurse would not sign off the treatment until it was performed. Record review of the face sheet revealed that the facility admitted Resident #2 on 7/28/21 with diagnosis that included Chronic Obstructive Pulmonary Disease. Record review of the MDS with an ARD of 5/28/26 revealed a BIMS score of 15, indicating that Resident #2 was cognitively intact.			F0842			