

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 08/19/2026	
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	
M0000	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, 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 the Minimum Standards for Institutions for the Aged or Infirm. An extended survey was completed, and the SA cited M615 at scope and severity level III for CI MS #3158751 and CI MS #3160082 at Past Non-Compliance. The SA also cited M735 for CI MS #3158751 and CI MS # 3160082. The SA cited M500 for CI MS #3109596 related to resident rights. There were no citations related to CI MS #3040024, CI MS #3063355, or 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.		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		M0500				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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M0500	Continued from page 1 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; 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			M0500			

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M0500	Continued from page 2 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 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			M0500			

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M0500	Continued from page 3 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: Level II 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 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 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			M0500			

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M0500	Continued from page 4 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 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.			M0500			

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M0500	Continued from page 5		M0500				
M0615	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. 45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level III 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 the facility was in compliance on 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		M0615	"Past Noncompliance - no plan of correction required"			

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M0615	Continued from page 6 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 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.			M0615			

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M0615	Continued from page 7 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 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			M0615			

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M0615	Continued from page 8 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 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.			M0615			

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M0615	Continued from page 9 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. 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. All corrective actions were completed on 8/14/2026 and the facility was in compliance on 8/15/2026. Validation: The State Agency (SA) validation of the corrective			M0615			

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M0615	Continued from page 10 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 as of 8/15/2026 prior to the SA entrance on 8/17/26.		M0615				
M0735	45.25.1 Medical Records Management Medical Records Management. 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary, including the final diagnosis. 5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records.		M0735				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/19/2026	
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
M0735	Continued from page 11 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge. 8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years. 9. A resident index, including the resident's full name and birth date, shall be maintained. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II 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			M0735			

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M0735	Continued from page 12 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 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			M0735			

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M0735	Continued from page 13 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 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.			M0735			