STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255161	A. BUILDING _____ B. WING _____	C 05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC BALDWYN NURSING FACILITY	739 4TH STREET SOUTH BALDWYN, MS 38824

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted a complaint survey for MS #17583 and MS #17742 at the facility on 05/26/21. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA substantiated Complaint MS #17583 for resident abuse concerning verbal abuse and cited F600 and F609 at a D level. MS #17742 concerning quality of care related to staffing was unsubstantiated with no deficiencies cited. Census at the time of the survey was 82 with a 107 bed capacity.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, record review and facility policy review, the facility failed to prevent verbal abuse for one (1) of nine (9) residents reviewed for abuse. Resident #1	F 600	" On an interview with the Administrator of the facility, this affected resident defined that he had not been abused by the deficient practice. Staff witnessing this action stopped the incident immediately	7/23/21

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

Electronically Signed | 07/01/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255161	A. BUILDING _____ B. WING _____	C 05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC BALDWYN NURSING FACILITY	739 4TH STREET SOUTH BALDWYN, MS 38824

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 1 Findings include: Review of facility policy titled, "Abuse: Recognizing Signs and Symptoms of Abuse and/or Neglect", dated 07/2018, revealed, "To provide guidelines to help protect the resident against abuse and/or neglect. It is the policy of (Proper Name of Facility) that residents should be protected against abuse and/or neglect." Review of facility policy titled, "Abuse: Protection of Resident(s) During Investigation", dated 07/2018, revealed "To provide guidelines to help protect resident's rights during investigations. It is the policy of (Proper Name of Facility) that residents' rights should be protected during investigations." Review of facility policy titled, "Abuse: In-Service Training On", dated 07/2018, revealed, "To provide guidelines for educating staff regarding spotting, reporting, and protecting against abuse. It is the policy of (Proper Name of Facility) that employees should be properly trained to spot, report, and protect against abuse". Review of facility policy titled, "Abuse: Background Screening", dated 07/2018, revealed, "To alleviate the employment of an individual guilty of abuse. It is the policy of (Proper Name of Facility) to not knowingly hire any individual who has a history of abuse or neglect". Review of facility policy titled, "Identifying and Reporting Abuse", undated, revealed, "Abuse includes willful infliction of injury, unreasonable confinement, intimidation, punishment and deprivation of goods or services that are necessary to attain or maintain physical, mental	F 600	and reported it to the Administrator. The offending employee was removed from this resident and all residents. This employee was interviewed. This employee gave a written statement. This employee was escorted to clock out and left the premises. This employee was suspended pending investigation. All these actions occurred on 2/18/21. " All other residents have the potential to be affected by the same deficient practice. " All staff will be in-serviced on Abuse and Neglect, how to report abuse, the timeline requirements to report abuse to state agencies, and Resident Rights. The employee was terminated after investigation on 2/22/21. A report was made to State Board of Nursing for their review on 6/01/21. The resident was documented by: Administrator, Assistant Administrator, Social Worker, Nurse, Nurse Practitioner, or Medical Director; who each reported no issues related to this incident. This resident's record has entries twice a week for three weeks, then once a week for two weeks, beginning 2/18/21 through 3/25/21. " Beginning 6/21/21 until 9/30/21, the Administrative Council will review the in-services and education process for staff and residents about abuse and neglect, reporting abuse, and any suspected incidents of abuse and neglect. The Daily Huddle meeting will review reports of suspected abuse or neglect and reporting process as required, started 6/21/21 and on-going. The July and October Quarterly QAPI Meeting will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255161	A. BUILDING _____ B. WING _____	C 05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC BALDWYN NURSING FACILITY	739 4TH STREET SOUTH BALDWYN, MS 38824

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 2 and psychosocial well-being. Abuse results in physical harm, pain or mental anguish. Types of abuse include verbal, mental, physical, sexual, neglect, involuntary seclusion and misappropriation of resident property". Policy revealed, "Abuse must be reported immediately to the nursing home administrator or a supervisor, who then is required to inform the administrator. Suspicion of crime must be reported to both the State Agency and local law enforcement immediately, within 2 hours if there is serious bodily injury and cases of abuse and neglect." Review of facility policy titled, "What Are Residents' Rights", undated, revealed, "The 1987 Nursing Home Reform Law requires each nursing home to care for its residents in a manner that promotes and enhances the quality of life of each resident, ensuring dignity, choice, and self-determination. Right to Dignity, Respect, and Freedom: To be treated with consideration, respect, and dignity; to be free from mental and physical abuse, corporal punishment, involuntary seclusion, and physical and chemical restraints." Record review of face sheet revealed Resident #1 was admitted to the facility on 12/6/2018 with diagnoses of Cerebral Ischemia; Peripheral Vascular Disease; Ataxia; Essential (Primary) Hypertension; Type 2 Diabetes Mellitus without Complications; Anxiety Disorder; Abnormalities of Gait and Mobility. Review of Minimun Data Set (MDS) dated 3/23/2021, revealed Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15, making him interviewable and cognitively able to answer questions.	F 600	review these in-services and reviews of suspected abuse and neglect, and reporting suspected abuse for recommendations and follow-up actions if needed. July QAPI will review the policies and will recommend any changes to the policies of: Protecting Residents from Abuse, Dignity and Respect, Recognizing the signs and Symptoms of Abuse and/or Neglect, Abuse Investigation and Reporting, and In-Service Training on Abuse.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255161	A. BUILDING _____ B. WING _____	C 05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC BALDWYN NURSING FACILITY	739 4TH STREET SOUTH BALDWYN, MS 38824

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 3	F 600		

Interview with Administrator on 5/26/2021 at 10:00 AM, revealed on 2/18/2021, an employee of the facility, Licensed Practical Nurse (LPN) #1 was involved in an incident of verbal abuse against Resident #1. Stated the facility immediately started an investigation of the incident and the employee was suspended while the investigation was in progress. After the investigation was complete, the employee was terminated. Stated the resident did not feel as though he had been verbally abused and was unaware of what LPN #1 had called him. Confirmed the facility failed to report the incident timely since the resident had stated he did not see the incident as abuse and did not feel threatened or unsafe. Stated the facility staff discussed the incident with the hospital administration the facility is part of and decided this incident was verbal abuse and it was then reported to the Attorney General's Office and the Department of Health.

Interview on 5/26/2021 at 11:20 AM, with Resident #1 concerning the incident under investigation. The resident stated it was no major issue for him and he did not feel unsafe or threatened in any way. He stated it was not right what the LPN said, but he, himself, was mad and he did not hear what was said. He was told what the nurse called him but stated he did not hear him actually say it. He stated at the time of that incident, he was needing something, and the nurse was taking a break. When the nurse came out of the breakroom, the resident said he just lost his temper with the nurse. He cooled down and was sorry he lost his temper. He stated another nurse gave him his medication that he was asking for, so he did not have to wait for it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255161	A. BUILDING _____ B. WING _____	C 05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC BALDWYN NURSING FACILITY	739 4TH STREET SOUTH BALDWYN, MS 38824

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 4	F 600		

Interview with Registered Nurse (RN #1 Charge Nurse) on 5/26/2021 at 4:00 PM revealed she was at the desk and witnessed the incident. She stated the staff separated Resident #1 from LPN #1. She gave the resident the medication he was requesting for diarrhea. She stated Resident #1 was calm and not in distress after incident and no additional medications or interventions were needed.

Interview with the Director of Nursing (DON) on 5/26/2021 at 4:10 PM, revealed the incident concerning Resident #1 and Licensed Practical Nurse (LPN) #1 was determined to be verbal abuse. Stated even though the resident did not feel threatened or abused from the incident, the facility could not risk this type of behavior occurring again. Confirmed the facility failed to report the incident of abuse within the required time frame. Stated it was discussed with the facility staff and the hospital administration the facility is part of and decided even though this resident was not bothered by the incident, the facility could not risk this behavior happening again or escalating into more abuse with other residents. Stated LPN #1 had been in-serviced on abuse and neglect and resident's rights. Confirmed the incident of verbal abuse occurred in the facility and it was the facility's responsibility to ensure abuse did not occur. Stated the staff was in-serviced on "Identifying and Reporting Abuse" 4/7/2021-4/8/2021. Sign in sheets were verified. Stated the staff is also required to complete computer-based training on resident's rights.

Interview with Administrator on 5/26/2021 at 4:15 PM, he stated the facility did a background check

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255161	A. BUILDING _____ B. WING _____	C 05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC BALDWYN NURSING FACILITY	739 4TH STREET SOUTH BALDWYN, MS 38824

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 5	F 600		

and trained LPN #1 on abuse and neglect and resident rights. Stated LPN #1 had been a good nurse at the facility and this type of behavior was not his usual way of behaving. Stated it is difficult to know how each employee could respond to certain situations. Stated the facility has meaasures in place, such as background checks and Abuse/Neglect/Resident Rights training to prevent abuse from occurring. The Administrator confirmed the verbal abuse of a resident by a facility employee occurred in the facility and even though measures were taken, the facility failed to prevent the verbal abuse. Stated he is the person responsible for notifying the Attorney General's Office and the Mississippi Department of Health. Stated he is aware that an allegation of abuse should be reported within 2 hours and the facility failed to report within this time frame and did not report the incident until 02/23/21.

Phone interview with LPN #1 on 5/31/2021 at 4:15 PM, revealed details of the incident with Resident #1. LPN #1 stated he had "a lot of stress at home and it just got the better of me." Stated he had gone into the break room just to relax for a few minutes and when he came out, the resident was angry at him for taking a break. Stated as a reaction to the resident's anger, he responded with, "I should not have to take that abuse from an asshole." Stated he did not threaten the resident in any way, and he would not have harmed him. Stated he was trained by the facility on abuse and neglect and on resident's rights and him calling the resident that name went against the resident's rights. Stated he wrote his account of the incident in a statement, and it was given to the Administrator.
.
Interview with the facility's Nurse Practitioner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255161	A. BUILDING _____ B. WING _____	C 05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC BALDWYN NURSING FACILITY	739 4TH STREET SOUTH BALDWYN, MS 38824

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 6	F 600		

(NP), on 6/1/2021 at 8:15 AM, revealed she was a witness to the incident. Stated the written statement in the report filed is her account of the incident that occurred between LPN #1and Resident #1. Stated she had never seen LPN #1 have a negative reaction like she witnessed that day. Stated he had always been a good nurse to work with and they had worked together that morning making rounds and doing care on the residents. Stated Resident #1 was fine immediately after the incident occurred and no negative outcomes were observed. Stated Resident #1 told her that he hated that he had become so irritated with LPN #1 and that his irritation led to the incident happening.

Review of LPN #1's on-hire training dated 6/9/2020, revealed he was in-serviced on Vulnerable Adults, Dementia and Abuse Education, Resident's Rights, Resident Abuse and Exploitation Film.

Review of letter from the State Department of Health dated 6/3/2020, revealed "the state and national criminal history record check processed by this agency found no violations that prevent (Proper name) LPN #1 from working with patients, residents or clients being served by a licensed hospital, nursing home, personal care home, home health agency or hospice."

Review of LPN #1's personnel record revealed he was hired by the facility on 6/9/2020 and his last day to work was 2/18/2021.

Review of LPN #1's time card revealed on 2/18/2021, he clocked in at 06:44 AM and clocked out at 11:29 AM and that was noted to be his last day to work at the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255161	A. BUILDING _____ B. WING _____	C 05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC BALDWYN NURSING FACILITY	739 4TH STREET SOUTH BALDWYN, MS 38824

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 7	F 600		

Review of LPN #1's Separation Notification dated 4/1/2021, revealed LPN #1's last day to work was 2/18/2021 and reason for separation was listed as Involuntary Separation (Termination) - Disruptive Behavior.

Review of Vulnerable Adult Abuse/Neglect Incident Report Form revealed the circumstances surrounding the incident: "The resident, (Proper Name) Resident #1, was verbally abused by an employee, (Proper Name) LPN #1, on 2/19/2021 (all other dates show 2/18/2021) at approximately 11 AM. This was witnessed by the Nurse Practitioner and Charge Nurse. That morning, the employee was on break in the breakroom, and he did not hear the overhead page for assistance. When he came out, the resident was asked (LPN #1 Proper Name) where he was because he needed medicine for diarrhea, and he couldn't find him. (Proper Name) LPN#1 laughed at this, and the resident made some comments that included an insult toward (Proper Name) LPN #1. As the resident and employee exchanged words, (Proper Name) LPN#1 called the resident an "asshole". The two were immediately separated by the Charge Nurse, who reported it to the Assistant Director of Nursing (ADON) (Proper Name). ADON (Proper Name) reported it to the Administrator, and the Administrator, ADON, and (Proper Name) LPN#1 met to discuss the incident. (Proper Name) LPN #1 was escorted out of the facility and placed on suspension until the investigation was complete. The Administrator discussed the incident with the resident stated he did not feel threated or abused. He was not afraid of (Proper Name) LPN #1. However, upon completion of the investigation and recommendations from Human Resources,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255161	A. BUILDING _____ B. WING _____	C 05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC BALDWYN NURSING FACILITY	739 4TH STREET SOUTH BALDWYN, MS 38824

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 8	F 600		

(Proper Name) LPN#1 was terminated on 2/22/2021."

The Vulnerable Adult Abuse/Neglect Incident Report Form revealed what immediate action(s) were taken to protect the resident. Revealed "the incident was witnessed by the Charge Nurse and the Nurse Practitioner who intervened by stepping between the employee and resident and tried to calm down both of them. This may have contributed to the resident not hearing the statements made by the employee. (See resident's account of the incident in the Administrator's statement). The resident was immediately moved from the nurse's station by the Charge Nurse who gave the resident his medication. The employee immediately left the station and was asked to go to the Conference Room to speak with the Administrator and ADON. Nursing Leadership was pulled to work the floor and did not report any issues or concerns from the resident." Review of the Vulnerable Adult Abuse/Neglect Incident Report Form revealed what immediate steps were taken to prevent the incident from recurring. Revealed "LPN #1 (Proper Name) was placed on suspension by the Administrator and left the facility at approximately 11:30 AM. The Administrator interviewed the resident at 1:20 PM to discuss the incident. The resident stated he did not feel threatened or abused, and he was not afraid of the employee. (See statement from the Administrator in the attachment.) Review of Incident Report Form revealed the provider, (Proper Name), NP, was notified and Responsible Party, (Proper Name), son, was notified, and State Agency was notified. Written statement from (Proper Name), Administrator, dated 2/18/2021 at 1:20 PM, revealed, "I visited with Resident #1 (Proper

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255161	A. BUILDING _____ B. WING _____	C 05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC BALDWYN NURSING FACILITY	739 4TH STREET SOUTH BALDWYN, MS 38824

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 9	F 600		

Name). He was in the D-Hall "cove area" with (Proper Name of another resident). I asked him if we could speak and if he would speak to me in private about something that happened today. Resident #1 (Proper Name) said that he would speak to me, but he would like to have (Proper Name of other resident) as a witness and speak where they were. I told him that that would be fine. I asked if I could sit with him and he agrees. I asked what happened. (Proper Name) Resident #1 said that he had turned on his call light and it was on for a while when (Proper Name) NP answered it. He wanted an Imodium. (Proper Name) Resident #1 said that, 'when (Proper Name) LPN #1 came, I guess I teed him off by saying you've been on your ass.' (Proper Name) Resident #1 described (Proper Name) Resident #1 as pointing at him and saying, 'after all I've done for you ...I'm going home'. I asked (Proper Name) Resident #1 if he felt threatened or abused. The resident said, 'no, I'm not afraid of him. I don't want him fired'. I explained to the resident that he should never feel afraid and to please tell me if he feels that way or is someone else does. I added that (Proper Name of the other resident) has my number and I'll give it to him or ask (Proper name for other resident) for it. (Proper Name for other resident) nodded in agreement. I told (Proper Name) Resident #1 that (Proper Name) LPN #1 was suspended pending a decision but if he is reinstated would be have a problem with him working in his area. (Proper Name) Resident #1 said that he had no problem and did not want him fired." Signed by (Proper Name), Administrator

Written statement from (Proper Name), RN #1, Charge Nurse, dated 2/18/2021 at 12:13 PM, revealed, "2/18/2021 @ 1100, (Proper Name), NP

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255161	A. BUILDING _____ B. WING _____	C 05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC BALDWYN NURSING FACILITY	739 4TH STREET SOUTH BALDWYN, MS 38824

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 10	F 600		

was at Station 1 desk. She (Proper Name) NP and I were discussing resident care. Resident, (Proper Name) (Resident #1), C2W, was wheeling up to the desk at Station 1. (Proper Name), NP asked if I had seen (Proper Name), LPN #1. (Proper Name) NP stated that she was paging for him. (Proper Name) Resident #1 asked where (Proper Name) LPN #1 was and that he (Proper Name) Resident #1 needed immodium. I (Proper Name) (RN #1) went my med cart to get the requested OTC (over the counter) med. When I got back to resident and desk, (Proper Name) LPN #1 came from breakroom. Resident asked (Proper Name) LPN #1 'where have you been?' (Proper Name), NP told (Proper Name) LPN #1 resident needed med for diarrhea. (Proper Name) LPN #1 began to laugh. Resident #1 (Proper Name), asked (Proper Name) LPN #1 'so you think that is funny?' (Proper Name) LPN #1, 'a little bit'. (Proper Name) Resident #1, 'while you're sitting on your ass', (Proper Name) LPN #1 'well I think do enough for you, I am not your maid'. I began attempting to get resident to take medicine. (Proper Name) NP tried to calm (Proper Name) LPN #1. (Proper Name) LPN #1 said 'I don't appreciate this/his ungrateful attitude from this asshole'. Resident was removed from desk. (Proper Name) LPN #1 stated he was leaving. Resident was shaking during event. But was calm and took medications and went to bed to have lunch." Signed (Proper Name) RN #1, Charge Nurse

Written statement from (Proper Name), NP, dated 2/18/2021 at 11:50 AM, revealed, "Around 11 AM this AM 2/18/2021, (Proper Name) (LPN #1) came out of breakroom. (Proper Name) (Resident #1) was sitting at desk getting an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255161	A. BUILDING _____ B. WING _____	C 05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC BALDWYN NURSING FACILITY	739 4TH STREET SOUTH BALDWYN, MS 38824

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 11	F 600		

Imodium from (Proper Name), (RN #1). He had been calling on call light x 30 minutes to see (Proper Name) (LPN #1) and get Imodium. (Proper Name) (LPN #1) was paged overhead and I called his phone with no answer. So when he showed up at desk, I asked 'where have you been. I paged you overhead and called your phone. (Proper Name) (LPN #1) said, 'I was in breakroom' and (Proper Name) (LPN #1) chuckled. (Proper Name) (Resident #1) said to (Proper Name) (LPN#1) 'do you think that's funny?' (Proper Name) (LPN #1) said 'yes'. (Proper Name) (Resident #1) said 'well, it ain't . It's not funny while you sit on your ass in the breakroom and do nothing.' (Proper Name) (LPN #1) said 'I do enough for you'. More words were exchanged. (Proper Name) (LPN #1) said 'I'm not your maid'. (Proper Name) (Resident #1) said more words ...(Proper Name) (LPN #1) said 'you're an asshole and I not taking this abuse from you'. Then (Proper Name) (LPN#1) walked away. I did try to stand between the both of them and talk (Proper Name) (LPN #1) down. (Proper Name) (RN #1 Charge Nurse) stood by (Proper Name) (Resident #1) and tried to talk him down as well." Signed by (Proper Name), NP

Written statement from (Proper Name), LPN (#1), dated 2/18/2021 at 11:10 AM, revealed, "Upon leaving the breakroom, (Proper Name) (NP) asked where I had been. She stated she had paged me. I stated I was in the breakroom and chuckled. Resident (Proper Name) (Resident #1) stated 'you think that's funny?' (Proper Name) (NP) stated (Proper Name) (RN, Charge Nurse) had given (Proper Name) (Resident #1) 2 Imodium.' I stated, 'yeah just a little funny'. As I tried to play off the poor attitude (Proper Name) (Resident #1) was producing. 'Its not funny. You

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255161	A. BUILDING _____ B. WING _____	C 05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC BALDWYN NURSING FACILITY	739 4TH STREET SOUTH BALDWYN, MS 38824

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 12	F 600		

need to be doing your damn job,' (Proper Name) (Resident #1) stated. 'I'm not a slave. I don't need to take this attitude', I said. 'Maybe if you got up off your ass and did something.' 'I won't take this crap from an asshole. I do enough for you.' Stated verbatim with (Proper Name) (NP), (Proper Name) (RN #1, Charge Nurse) as witnesses." Signed by (Proper Name) (LPN #1)

Review of Resident #1's Instant Careplan dated 2/18/2021 for problem/risk of verbal abuse with goal for resident to be safe and free from abuse. New order/other listed as frequent monitoring for psychological and emotional support and administrator interviewed resident.

Review of Resident #1's Care Plan revealed a care plan for resident being vulnerable and is at increased risk for abuse, neglect, financial exploitation, and misappropriation of property related to physical impairment. Interventions included: assess for vulnerability by comprehensive assessment to include MDS, client/family interview, physical/cognitive examination, review of medical history and medication use; observe and report possible abuse, neglect and exploitation of resident; safety - remove resident from potential abuse/harm/neglect. Document and report as indicated; follow facility protocol for investigation and report of abuse.

Review of Resident #1's care plan revealed a care plan for psychotropic med use related to history of Depression. Interventions included: observe for side effects and for effectiveness of medications; pharmacy review of medications with dose reduction as ordered; administer meds as ordered; observe for mood/behaviors - monitor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255161	A. BUILDING _____ B. WING _____	C 05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC BALDWYN NURSING FACILITY	739 4TH STREET SOUTH BALDWYN, MS 38824

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 13 for pain. Document and report as indicated; Evaluate and provide services/referrals as needed; relaxation (music, deep breathing, guided imagery and distraction (tv, music, radio, conversation, singing, reading, counting activities. Review of Resident #1's care plan revealed a care plan for impaired communication related to bilateral loss. Observations included: observe and anticipate needs, assist as needed; face resident when speaking to him, speak clearly and adjust tone as needed; ask yes/no questions and allow time to respond - repeat and confirm; remove background noise as possible, when speaking to resident; observe resident for non-verbal gestures.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established	F 609		7/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255161	A. BUILDING _____ B. WING _____	C 05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC BALDWYN NURSING FACILITY	739 4TH STREET SOUTH BALDWYN, MS 38824

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 14 procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to timely report an incident of verbal abuse for one (1) of nine (9) residents reviewed for abuse, Resident #1. Findings Include: Review of facility policy titled, "Identifying and Reporting Abuse", undated, revealed, "Abuse includes willful infliction of injury, unreasonable confinement, intimidation, punishment and deprivation of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Abuse results in physical harm, pain or mental anguish. Types of abuse include verbal, mental, physical, sexual, neglect, involuntary seclusion and misappropriation of resident property". Policy revealed, "You are required to report all suspected abuse as soon as possible. Abuse must by reported immediately to the nursing home administrator or a supervisor, who then is required to inform the administrator. Suspicion of crime must be reported to both the State Agency and local law enforcement immediately, within 2 hours if there is serious bodily injury and cases of abuse and neglect".	F 609	" On an interview with the Administrator of the facility, this affected resident defined that he had not been abused by the deficient practice. Staff witnessing this action stopped the incident immediately and reported it to the Administrator. The offending employee was removed from this resident and all residents. This employee was interviewed. This employee gave a written statement. This employee was escorted to clock out and left the premises. This employee was suspended pending investigation. All these actions occurred on 2/18/21. " All other residents have the potential to be affected by the same deficient practice. " All staff will be in-serviced on Abuse and Neglect, how to report abuse, the timeline requirements to report abuse to state agencies, and Resident Rights. The employee was terminated after investigation on 2/22/21. A report was made to State Board of Nursing for their review on 6/01/21. The resident was documented by: Administrator, Assistant Administrator, Social Worker, Nurse, Nurse Practitioner, or Medical Director;	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255161	A. BUILDING _____ B. WING _____	C 05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC BALDWYN NURSING FACILITY	739 4TH STREET SOUTH BALDWYN, MS 38824

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 15 Review of facility policy titled, "What Are Residents' Rights", undated, revealed, "The 1987 Nursing Home Reform Law requires each nursing home to care for its residents in a manner that promotes and enhances the quality of life of each resident, ensuring dignity, choice, and self-determination. Right to Dignity, Respect, and Freedom: To be treated with consideration, respect, and dignity; to be free from mental and physical abuse, corporal punishment, involuntary seclusion, and physical and chemical restraints. Interview with Administrator on 5/26/2021 at 10:00 AM, revealed on 2/18/2021, an employee of the facility, Licensed Practical Nurse (LPN) #1 was involved in an incident of verbal abuse against Resident #1. Stated the facility immediately started an investigation of the incident and the employee was suspended while the investigation was in progress. After the investigation was complete, the employee was terminated. Stated the resident did not feel as though he had been verbally abused and was unaware of what LPN #1 had called him. Confirmed the facility failed to report the incident timely since the resident had stated he did not see the incident as abuse and that the resident stated he did not feel threatened or unsafe. Stated the facility staff discussed the incident with the hospital administration the facility is part of and decided this incident was verbal abuse and it was then reported to the Attorney General's Office and the Department of Health on 2/23/2021. Interview with the Director of Nursing (DON) on 5/26/2021 at 4:10 PM, revealed the incident concerning Resident #1 and Licensed Practical Nurse (LPN) #1 was determined to be verbal	F 609	who each reported no issues related to this incident. This resident's record has entries twice a week for three weeks, then once a week for two weeks, beginning 2/18/21 through 3/25/21. " Beginning 6/21/21 until 9/30/21, the Administrative Council will review the in-services and education process for staff and residents about abuse and neglect, reporting abuse, and any suspected incidents of abuse and neglect. The Daily Huddle meeting will review reports of suspected abuse or neglect and reporting process as required, started 6/21/21 and on-going. The July and October Quarterly QAPI Meeting will review these in-services and reviews of suspected abuse and neglect, and reporting suspected abuse for recommendations and follow-up actions if needed. July QAPI will review the policies and will recommend any changes to the policies of: Protecting Residents from Abuse, Dignity and Respect, Recognizing the signs and Symptoms of Abuse and/or Neglect, Abuse Investigation and Reporting, and In-Service Training on Abuse.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255161	A. BUILDING _____ B. WING _____	C 05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC BALDWYN NURSING FACILITY	739 4TH STREET SOUTH BALDWYN, MS 38824

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 16	F 609		

abuse. Stated even though the resident did not feel threatened or abused from the incident, the facility could not risk this type behavior occurring again. Confirmed the facility failed to report the incident of abuse within the required time frame. Stated it was discussed with the facility staff and the hospital administration the facility is part of and decided even though this resident was not bothered by the incident, the facility could not risk this behavior happening again or escalating into more abuse with other residents. Confirmed the incident of verbal abuse occurred in the facility and it was the facility's responsibility to ensure abuse did not occur.

Interview with Administrator on 5/26/2021 at 4:15 PM. Stated the facility did a background check and trained LPN #1 on abuse and neglect and resident rights. Stated LPN #1 had been a good nurse at the facility and this type behavior was not his usual way of behaving. Stated it is difficult to know how each employee could respond to certain situations. Stated the facility does background checks and in-services for each employee to try to prevent any abuse from occurring, but even with all of these measures in place, the facility cannot always know this type behavior could occur. The Administrator confirmed the verbal abuse of a resident by a facility employee occurred in the facility and even though measures were taken, the facility failed to prevent the verbal abuse. Stated he is the person responsible for notifying the Attorney General's Office and the Mississippi Department of Health. Stated he is aware that an allegation of abuse should be reported within 2 hours and the facility failed to report within this time frame.

Pnone interview with LPN #1 on 5/31/2021 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255161	A. BUILDING _____ B. WING _____	C 05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC BALDWYN NURSING FACILITY	739 4TH STREET SOUTH BALDWYN, MS 38824

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 17	F 609		

4:15 PM revealed details of the incident with Resident #1. LPN #1 stated he had "a lot of stress at home and it just got the better of me." Stated he had gone into the break room just to relax for a few minutes and when he came out, the resident was angry at him for taking a break. Stated as a reaction to the resident's anger, he responded with, "I should not have to take that abuse from an asshole." Stated he did not threaten the resident in any way and he would not have harmed him. Stated he was trained by the facility on abuse and neglect and on resident's rights and him calling the resident that name went against the resident's rights.

Review of Face Sheet revealed Resident #1 was admitted to the facility on 12/6/2018. Resident #1 with diagnoses of Cerebral Ischemia; Peripheral Vascular Disease; Ataxia; Essential (Primary) Hypertension; Type 2 Diabetes Mellitus without Complications; Anxiety Disorder; Abnormalities of Gait and Mobility. Review of MDS - Section C-Cognitive, dated 3/23/2021, revealed a BIMS score of 15.

Review of LPN #1's on-hire training dated 6/9/2020, revealed in-services on Vulnerable Adults, Dementia and Abuse Education, Resident's Rights, Resident Abuse and Exploitation Film.

Review of the notifications to the Attorney General's office and the the State Department of Health were noted to have been sent on 2/23/2021.