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 05/02/2023

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

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F 000	INITIAL COMMENTS The State Agency (SA) conducted two (2) Complaint Investigations (CI MS #20942 and CI MS #21055) at the facility from 05/01/23 through 05/02/23. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services and cited F609 for failure to report allegations of verbal abuse related to CI MS # 20942. The SA determined the facility was in compliance for CI MS #21055. The census at the time of the complaint survey was 96 with a license for 107 bed capacity.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(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 procedures.	F 609		6/6/23

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

Electronically Signed | 05/16/2023

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 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.

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F 609	Continued From page 1 §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, resident, and resident family interviews, record review and facility policy review, the facility failed to identify and report an incident of alleged verbal abuse for one (1) of five (5) residents reviewed. Resident #1. Findings include: Record review of facility policy with revision date of 03/20 titled: "Abuse: Investigation and Reporting" revealed," ... . Rationale: To provide guidelines to help protect, report, and investigate abuse allegations. Policy: It is the policy of (Proper Name) Nursing Facility that all reports of suspected resident abuse, neglect and injuries should be properly reported and investigated ... ...Procedure: When investigating reports of suspected resident abuse, neglect and injury, the guidelines below should be followed: ....3. The individual conducting the investigation should, as a minimum ... ...j. Report allegations to the State Licensure and Certification and to the Attorney General within 24 hours of report and in writing within 72 hours of the report." On 05/01/23 at 9:20 AM, a phone interview with, Resident #1's granddaughter revealed that on 03/02/23 Resident #1 had called her daughter and was on the phone when Registered Nurse (RN) #1 came into Resident #1's room and yelled	F 609	1. Abuse was unsubstantiated through internal investigation by the Baldwyn Leadership team at the time of the incident on 3/3/2023. The offending employee, Registered Nurse (RN) #1 was immediately removed from the care of Resident #1 at the time of the incident on 3/3/2023 and was coached on the situation by the Director of Nursing (DON). Resident #1 was discharged from the facility to local Behavioral Health on 3/10/2023 and did not return. 2. All residents of the facility have the potential for the same deficient practice. 3. The offending employee, RN #1 was immediately removed from the care of Resident #1 at the time of the incident on 3/3/2023 and was coached on the situation by the Director of Nursing (DON). An in-service education started on 5/3/2023 and is currently on-going being conducted by the Clinical Educator with all staff on Abuse and Neglect, how to report abuse, the timeline requirements to report abuse to state agencies, and Resident Rights. This is to be completed by 5/24/22. This education will continue to be included in our new hire orientation as	

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F 609	Continued From page 2 at her saying, "You are killing yourself'.RN #1 then Resident #1's phone. The resident's daughter heard the conversation and was upset that this nurse would speak to her mom in this manner. On 05/01/23 at 4:15 PM, during a phone interview with Resident #1's daughter revealed that Resident #1 doesn't sleep much. Resident #1 enjoyed playing games on her phone that she bought for her and revealed that Resident #1 had called her early one morning by accident and while on the phone, the daughter overheard RN #1 yelling at her mom. RN#1 said, "You need to go to sleep, you're gonna kill yourself!" Resident #1's daughter revealed that she could hear her mom crying and she immediately hung up the phone and called the facility and talked to RN #1. The resident's daughter stated, "RN #1 said, 'Yes, I bawled your mama out' and then commenced to bawl me out." She revealed that this nurse was removed from her mom's care and that they had moved Resident #1 to a different nursing home. On 05/02/23 at 8:30 AM, an interview with RN #1 revealed that on the night of 03/02/23, Resident #1 was up wandering, going in and out of other resident rooms, was sluggish, staggering, confused and disoriented. RN #1 revealed that Resident #1 had been up for nearly 72 hours without sleep. She was concerned about her and tried to talk her into going to sleep. She said, "She couldn't keep going like this without no sleep." RN #1 revealed that the facility didn't use alarms or bedrails and that Resident #1 had already had a couple of falls, so she was worried about her. RN #1 also revealed that she did talk loudly because she was hard of hearing, and she could see why it might come across that she was fussing at the resident but wasn't meant that way.	F 609	well. Facility Social Worker will review “A Matter of Rights” with Resident Council and all alert residents on 5/24/2023. This review is done on admission and will continue to be done annually as well. A log will continue to be maintained by the Assistant Administrator that documents all reportable notifications to the State Agency and the State of Mississippi Attorney General. 4. Beginning 5/15/2023 until 6/6/2023, the Administrative Council will review reports weekly for 3 weeks of suspected abuse, neglect, and the reporting process required. Reports of any suspected abuse, neglect, and reporting process required will be reviewed daily in Daily Huddle starting 5/15/2023 and be on-going indefinitely. The results based from verbal exit from the Complaint Survey were reported to the Quality Assurance and Performance Improvement (QAPI) Committee on May 16, 2023. These results along with the written statement of deficiencies report (CMS-2567) were reviewed. Recommendations from the QAPI committee will be implemented as required, monitored until compliance is achieved, and will be up for review at the facility’s next QAPI committee meeting scheduled for 6/6/2023. We will continue to review the reportable incident logs maintained by the Assistant Administrator at our quarterly QAPI meetings indefinitely.	

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RN #1 said, "I was just trying to get her to lie down in her bed and get some sleep."

On 05/02/23 at 9:15 AM, an interview with Assistant Director of Nursing (ADON) revealed that when the incident between Resident #1 and RN #1 was reported to her she didn't realize that it was a reportable incident. The ADON revealed that she and the Director of Nursing (DON) talked to the resident, the resident's daughter, the resident's roommate and that they did not feel that it was abuse. The ADON said that the daughter seemed to be okay with it when RN #1 was no longer allowed to care for her mother. The ADON revealed that she understood and could see now why it should have been reported and would make sure it was handled differently in the future.

On 05/02/23 at 10:00 AM, a phone interview with RN #2 revealed that around 6:30 AM or 7:00 AM on the morning of 03/03/23 that Resident #1's daughter reported to her that RN #1 had yelled at her mom. The daughter told her that her mom had accidentally called her and while listening, she heard RN #1 chastising her mom and that her mom was upset and crying. RN #2 revealed that she immediately reported this to the DON and the ADON. RN #2 also revealed that the incident was immediately investigated.

On 05/02/23 at 10:40 AM, an interview with ADON revealed that when an abuse situation was suspected, they would make sure that the residents were safe and then they would report it. The ADON revealed that she did know that an alleged abuse situation was supposed to be reported within 24 hours but usually they tried to report anything within 2 hours to err on the side of

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caution. She revealed that she was not sure if this incident had been reported or not. The ADON revealed that they did an investigation, interviewed the daughter and other residents, intervened, and completed in-services with all employees. The ADON said that they removed RN #1 from Resident #1's care and the family were good with everything.

On 05/02/23 at 11:00 AM, an interview with the Administrator revealed that they did not report the incident between Resident #1 and RN #1 because they had investigated it and had determined that it was not abuse. He revealed that he did not think that this situation should have been reported.

On 05/02/23 at 12:30 PM, an interview with Director of Nursing (DON) revealed that on the morning of 03/03/23, RN #2 reported the occurrence between Resident #1 and RN #1 to him and the ADON. The DON revealed that he went straight to the resident's room and the daughter was still present and voiced her concerns to him as well. The DON said that he pulled RN #1 into his office to find out from her what occurred and that they immediately removed RN #1 from the care of the Resident #1. Since this seemed to appease the family, he thought that the problem was solved. The DON confirmed that he did not report this incident to the State Agency and that he now realized that this should have been done.

Record review of the Face Sheet revealed Resident #1 was admitted to the facility on 08/15/22 with diagnoses that included Acute Metabolic Encephalopathy, Cerebrovascular Accident with cognitive deficits, and Dementia in

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F 609	Continued From page 5 Alzheimer's Disease with depression. Record review of Resident #1's Minimum Data Set (MDS) dated 01/03/23 revealed a Brief Interview for Mental Status Score (BIMS) score of 09 which indicated that resident had severe cognitive impairment.	F 609		