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 05/25/2023

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 Complaint Investigations (CI) at the facility for, CI MS #21607, CI MS #21579, CI MS #21576 and CI MS #21554 from 5/24/23 through 5/25/23. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA investigated CI MS #21579 for Accidents and Administrative/personnel and did not cite any deficiencies. The SA investigated CI MS #21576 for Abuse and did not cite any deficiencies. The SA investigated CI MS #21554 for Quality of Care/Treatment for pressure ulcers prevention, Medical Doctor orders not followed, Call lights not answered timely, Residents left wet or soiled and did not cite any deficiencies. The SA investigated CI MS #21607 for Pharmaceutical Services and found that the facility was not in compliance and cited F761. At the time of survey, the facility had a census of 94 residents and was licensed for 107 beds.	F 000		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		6/10/23

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

Electronically Signed | 06/06/2023

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F 761	Continued From page 1 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, interviews and facility policy review, the facility failed to store drugs and biologicals appropriately as evidenced by a facility reported investigation of medications for the residents on A hall were found prepared and stored in medication cups for 20 residents in a night shift nurse's unlocked locker in the employee breakroom for one (1) of five (5) medication carts observed. Findings include: Record review of the facility's policy "Medication Administration" last modified 6/10/2020, revealed "Title: Medication Administration" 4. Storage of medications and several other associated products should be secure, i.e., in a locked med room in a locked drawer/cabinet, or under constant surveillance. Any product used in a therapeutic manner should be treated and administered as a medication ...10. All medication removed from a medications storage area should be removed just prior to administration and only for one patient at a	F 761	1. An immediate investigation by the Baldwyn Leadership team was conducted at the time of the incident on 5/15/2023. The offending employee, Registered Nurse (RN) #1 was immediately placed on administrative leave pending investigation. An immediate internal audit performed by the Assistant Director of Nursing (ADON) found that no narcotics were present in any of the medication cups. The medications found were either prescribed or over-the-counter medications. A Medication Administration Record (MAR) review for each resident on A Hall was performed by the ADON and no issues were found. 2. All residents of the facility have the potential for the same deficient practice. 3. The offending employee, RN #1 was immediately placed on administrative leave pending investigation. An in-service education was started on 5/18/2023 being	

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F 761	Continued From page 2 time..." Record review of a facility reported incident revealed that the incident was reported to the Administrator and the Director of Nursing (DON) on 05/15/23 around 1:15 PM. The incident revealed that Registered Nurse (RN) #1 had prepared medications for residents, in medication cups with the name of the resident on the outside of the medication cup and stored these medications in his locker inside a locked staff break room. This was investigated by the facility Administrator and Assistant Administrator and was reported to the State Agency (SA) and the Attorney General (AG) office at the time of the incident. Interview on 5/25/23 with the DON 10:00 AM, revealed that there had been an audit of the medication cups found in RN #1's locker and there were no narcotics found. The medications were either prescribed medications or over-the-counter medications that were ordered. Each medication cup had the last name of the resident written on the outside of the cup. The Medication Administration Records (MAR)'s were reviewed with no issues found. When he interviewed RN #1, he said that "He would preset meds for the next night he would come in. He would check for new orders. He did not say how long he had done this exactly. There were 20 separate cups." Interview with the Assistant Administrator on 5/24/23 at 10:15 AM, revealed that the stored medications in the locker was seen by a staff member,while on her lunch break in the break room. The staff member reported it to the Assistant Administrator and the Administrator. He	F 761	conducted by the Clinical Educator, Director of Nursing (DON), and ADON with all nursing staff to address proper medication storage and administration. This is to be completed by 6/11/2023. This education will continue to be included in our new hire orientation with all nursing staff as well. 4. Beginning 5/26/2023 Baldwyn Nursing Leadership comprised of the DON, ADON, and Clinical Educator will conduct 2 med cart audits weekly for 8 weeks for suspected improper medication storage and administration. The results based from verbal exit from the Complaint Survey were reported to the Quality Assurance and Performance Improvement (QAPI) Committee on June 6th, 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 3 months of QAPI committee meeting scheduled in 2023.	

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F 761	Continued From page 3	F 761		

said they immediately went to the staff break room and the locker door was open. There was no lock present on the employee locker. The medication cups were in two stacks and were stacked on top of each other with medical tape holding the cups together. He stated they immediately suspended RN #1 and began their investigation.

Observation by SA on 5/24/23 at 10:20 AM, of the staff break room revealed that the door required the staff member's identification card (ID) to open the door entering the breakroom. There was a wall with small staff lockers located in the breakroom, some are locked, and some are not locked, but it was observed that there was not a lock on RN #1's locker.

Review of the facility's investigation revealed an email written by RN #1 dated 5/16/2023 regarding the incident revealed he had "Done this for many months" and that he "Thought it was ok since the meds were locked in the locker and the lounge door is also locked." He stated that he locks his locker and was "worried" someone may have tampered with the medications. He wrote that the medications found were to be administered to residents the next time he worked.

Review of RN #1's personnel file revealed RN #1 had received training and testing on medication administration. There were no discipline actions in his file until this incident. He had worked for the facility since 2009. Currently, he is still suspended. The facility's Human Resources (HR) has the completed the investigation and will be following through with termination of this employment.

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F 761	Continued From page 4 The SA attempted to call RN#1 twice with no return phone calls on 5/24/23 and 5/25/23.	F 761		