STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255161	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC BALDWYN NURSING FACILITY	**739 4TH STREET SOUTH , BALDWYN, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted eleven (11) Complaint Investigations (CI MS #3030750, CI MS #3031740, CI MS #3035037, CI MS #3119268, CI MS #3137668, CI MS #3158296, CI MS #3166331, CI MS #3188866, CI MS #3194961, CI MS #3204428, and CI MS #3206215) at the facility from 09/14/2026 through 09/17/2026. During the survey, the SA determined that the facility was not in compliance with the requirements for participation in the Medicare and Medicaid programs. The SA cited F584 related to the physical environment for CI MS #3188866, CI MS #3194961, and CI MS #3204428; F600 related to abuse for CI MS #3119268; and F677 related to bathing/ADL care for CI MS #3137668 and CI MS #3204428. No deficient practice was identified related to the allegations for CI MS #3030750, CI MS #3031740, CI MS #3035037, CI MS #3158296, CI MS #3166331, or CI MS #3206215. Additionally, during the course of the complaint investigations, the SA identified deficient practices unrelated to the complaint allegations and cited F580 related to notification of changes and F760 related to significant medication errors. At the time of the survey was 80 with a bed capacity of 107 beds.	F0000		
F0600 SS = G	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	F0600		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0600 SS = G	Continued from page 1 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 record review, staff interviews and facility policy, the facility failed to protect a resident and ensure the resident's right to be free from physical abuse for one (1) of three (3) residents reviewed for abuse. Resident #1. Findings Include: A record review of the facility policy, "Abuse: Protecting Residents From," revised July 2016, revealed, "It is the policy of [Facility Name] that residents should be protected from abuse." Record review of a written statement from Registered Nurse (RN) #1 dated 07/29/26 at 8:43 PM, stated, "I was at the nurse station about 50 feet away when I heard (Resident #1) screaming crying in pain. It was a different crying than usually. As I walked into the room, (Resident #30) gave me a look of concern. I proceed to say what is going on. Certified Nursing Assistant (CNA) #1 shouted she don't want to get clean clothes on. CNA #1 kept telling (Resident #1) to be quiet, be quiet. I told CNA #1 to take a deep breath, and I keep trying to console Resident #1....and she kept saying hurt, hurt. I asked CNA #1 do you know her right arm is stiff and you have to be careful with it. She again said in a loud voice be quiet (Proper Name)!" The statement continued and she walked the CNA out of the room and RN#1 went back into the room alone to check with Resident #30 to ask what happened. The statement revealed that Resident #30 stated that CNA #1 was not nice to Resident #1 and acted like she didn't like her and that she doesn't act like she wants to take care of her and shows no patience towards her and just flips her over and stated she does not think she needs to take care of her (Resident #1) anymore. The State Agency (SA) attempted to call RN #1 on 09/16/26 with no success.	F0600		

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F0600 SS = G	Continued from page 2 During a post survey Interview with RN #1 on 09/23/26 at 3:08 PM stated, "I was about 30 feet or so from the room of Resident #1 and she was crying out and it was a painful cry. I walked down to her room and when I walked in, CNA #1 was telling Resident #1 to shut up, shut up, she just kept telling her that multiple times and Resident #1 was saying hurt, hurt and was crying. I stayed in the room and tried to console Resident #1 and told CNA #1 that her right arm is contracted and it hurts her and you have to be gentle with her. CNA #1 was agitated with the resident and continued to tell her to shut up. I finished helping to get her changed and walked CNA #1 out of the room. I then went back in the room to check on Resident #1 and that's when the roommate (Resident #30) was telling me that CNA #1 is not a nice person and she acts like she doesn't like Resident #1 and she would not want her taking care of anyone she knew, because she is not friendly and she is too rough with her." RN #1 stated she immediately reported this to the charge nurse. A record review of the facility's investigation revealed that on 07/27/2026 at 7:06 PM, staff were notified of an allegation of possible abuse involving CNA #1 and Resident #1. Resident #1's roommate, Resident #30, with a Brief Interview for Mental Status (BIMS) score of 15, reported observing CNA #1 speaking to Resident #1 in a "harsh manner and removing the resident's shirt in a rough manner while the resident was crying out and repeatedly stating that she was hurt." Record review of a body audit by RN #3, dated 07/27/26 at 8:20 PM revealed, "Patient noted to have redness and bruising to right dorsal hand. Redness noted to right upper shoulder. Blue bruising to left AC. Scratch to left forearm. Dried bloody scratch left upper leg. Patient softly talking unintelligible words. Tears running down patient cheeks. Patient mood is sad." A record review of the facility's investigation revealed CNA #1 was suspended pending investigation on 07/27/2026 and terminated following the investigation on 07/31/2026 after the facility substantiated the abuse. On 9/16/2026 SA attempted to call CNA #1, no answer and no call back. During an interview on 09/16/2026 at 10:25 AM, the Director of Nursing (DON) verified CNA #1 violated the facility's abuse and neglect policy and procedures and was terminated on 07/31/2026	F0600		

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F0600 SS = G	Continued from page 3 following the investigation of the incident. During an interview on 09/17/2026 at 9:30 AM, the Administrator verified the facility's investigation corroborated the allegation of abuse. A record review of Resident #1's Minimum Data Set (MDS) quarterly assessment with the Assessment Reference Date (ARD) of 06/17/2026 revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating the resident was severely impaired. A record review of the medical record revealed that the facility admitted Resident #1 on 03/04/2025 with diagnoses that included seizures, hemiparesis,speech and language deficits and cognitive deficits due to recent cerebral infraction.	F0600		
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-	F0580		

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F0580 SS = D	Continued from page 4 (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to notify the resident's practitioner of a reported medication error involving the administration of insulin to a resident who did not have an order for insulin for one (1) of four (4) residents reviewed for medication errors. Resident #3 Findings include: Record review of facility policy, titled "Medication Administration" revealed "Medication Variance" revealed "1. Any medication that has been incorrectly administered to a patient or has been omitted from the patient's regiment should be reported…The Registered Nurse in charge of the patient should provide information to the physician regarding the patient assessment." Record review of the facility's "Safety Solutions Alert," dated 05/06/2026 and addressed to the Director of Nursing (DON), revealed Resident #3 and his roommate reported that on 05/05/2026, prior to supper, a nurse administered an injection to Resident #3's left arm. Resident #3 reportedly informed the nurse that he did not receive injections, and his roommate informed the nurse that he was the resident for whom the nurse was looking.	F0580		

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F0580 SS = D	Continued from page 5 During an interview on 09/15/2026 at 8:36 AM, the DON verified she received notification of the allegation on 5/6/26 and stated the Nurse Practitioner (NP) was not notified because Registered Nurse (RN) #2 denied administering insulin to Resident #3. During an interview on 09/16/2026 at 1:21 PM, the NP verified she was not notified of Resident #3's report that he had received an insulin injection. The NP stated it was her expectation that she would have been notified so the resident could have received increased monitoring. Record review of the demographic sheet revealed the facility admitted Resident #3 on 3/25/25 with diagnoses that included Cerebral Infarction and Aphasia. Record review of the Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 7/1/26 revealed that the Brief Interview of Mental Status (BIMS) score of 15, indicating that the resident was cognitively intact.	F0580		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and	F0584		

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F0584 SS = D	Continued from page 6 comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview and facility policy review the facility failed to maintain the physical environment in safe and sanitary conditions for one (1) of three (3) common rooms used by residents. Activity Room. Findings include: Record review of the facility policy, titled “Resident Rights: Dignity and Respect" revealed, "To provide the kind of care to our residents that should maintain and enhance their dignity, individuality, and quality of live by the following...a living environment that is safe, clean, and comfortable." An interview on 09/16/26 at 1:10 PM, with Certified Nursing Assistant (CNA) #2, CNA #3, and CNA #4 verified that approximately two (2) weeks earlier, during the evening shift, a possum fell through a ceiling tile located immediately outside the Activity Room and entered the Activity Room. The CNAs stated they notified the Charge Nurse and the floor nurse, who contained the possum in a trash can and removed it from the facility. During an interview with Facility Operations #2 on 9/16/26 at 2:00 PM he verified that after being notified of the incident, he returned to the facility and observed a hole in the ceiling tile immediately outside the Activity Room. He inspected the area above the ceiling and did not observe any additional	F0584		

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F0584 SS = D	Continued from page 7 possums. He was unable to determine how the possum accessed the area. He replaced the damaged ceiling tile and verified the affected area was cleaned. During an interview on 9/16/26 at 2:51 PM, Licensed Practical Nurse (LPN) #1 verified that he observed a hole in the ceiling tile immediately outside the Activity Room and a possum inside the Activity Room. He stated that he and the Charge Nurse contained the possum in a trash can, covered the container with a lid, and removed it from the facility.	F0584		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and facility policy review the facility failed to ensure residents, who were dependent on staff for bathing, received scheduled bathing services for one (1) of 29 sampled residents. Resident #2 Findings Included: Record review of the facility policy titled, “Bathing” revealed, “Policy: It is the policy of [Proper Name of Facility] to promote patient cleanliness by assisting with bathing needs as appropriate.” Record review of a “Flowsheet History” for Resident #2, dated 8/17/26 through 9/16/26 revealed that she had been bathed one (1) time during that time period. Interview with Certified Nursing Assistant (CNA) #2, CNA #3 and CNA #4 on 9/16/26 at 1:00 PM, they revealed they follow the bathing schedule for their residents. Record review of “Resident Bath Schedule”, updated 9/11/26, revealed Resident #2 was scheduled to have a shower Monday, Wednesday, and Friday (MWF) on night shift. Record review of the “Flowsheet History” and interview with Director of Nursing (DON) on 9/16/26 at 1:14 PM, she verified that Resident #2 only had one (1) documented bath during that time period.	F0677		

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F0677 SS = D	Continued from page 8 Interview with the Administrator on 9/16/26 at 2:03 PM, he revealed that Resident #2 returned from the hospital in August, and her name had not been added back to the bathing sheet. He agreed there was no documentation to verify that she received a bathing during that time frame. Record review of a demographic sheet revealed the facility admitted Resident #2 on 1/13/26 with a diagnosis of Anoxic Brain Injury. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/20/2026 revealed Resident #2 was dependent for baths.	F0677		
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff and resident interview, and facility policy review the facility failed to ensure a resident was free from a significant medication error for one (1) of four (4) residents reviewed for medication errors. Resident #3. Findings include: Record review of facility policy, titled “Medication Administration” revealed “Policy: It is the policy of [Proper Name of Facility] that medication administration should be standardized to help improve patient care…Medication Administration…5. Two of the four following patient identifiers should be used prior to administration of any medication. For inpatients, this should be resident name, resident picture, resident date of birth or the medical record number.” Record review of the facility’s “Safety Solutions Alert,” dated 05/06/2026, revealed Resident #3 and his roommate reported that on 05/05/2026, prior to supper, a nurse administered an injection to Resident #3’s left arm. Resident #3 reportedly informed the nurse that he did not receive injections. His roommate then informed the nurse that he was the resident for whom the nurse was looking and subsequently received his insulin.	F0760		

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F0760 SS = D	Continued from page 9 During an interview on 09/15/2026 at 9:00 AM, Resident #3 verified the nurse checked his blood sugar and administered an insulin injection. During an interview on 09/16/2026 at 8:15 AM, Resident #4 verified that when he returned to the room, he observed the nurse administering insulin to his roommate, Resident #3. Resident #4 stated he informed the nurse that he was the resident she was looking for. During a telephone interview on 09/16/2026 at 11:48 AM, Registered Nurse #2 (RN) stated she did not usually work at the facility and had never worked that hall. RN #1 acknowledged she asked Resident #3 if he was Resident #4, and Resident #3 smiled and said yes. RN #1 stated she checked Resident #3's blood sugar but denied administering an injection. Record review of Resident #3's Physician Orders revealed Resident #3 had no order for insulin. Record review of "All Medications from Tuesday 5/5/26 9:00 AM to Tuesday 5/5/26 5:00 PM" for Resident #4 revealed orders for Insulin Aspart (Novolog), including sliding-scale insulin and 24 units of insulin three (3) times daily with meals. Record review of the demographic sheet revealed the facility admitted Resident #3 on 3/25/25 with diagnoses that included Cerebral Infarction and Aphasia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/1/26 revealed that the Brief Interview of Mental Status (BIMS) score of 15, indicating that the resident was cognitively intact. Record review of the demographic sheet revealed the facility admitted Resident #4 on 9/6/24 with diagnoses that included Diabetes Mellitus with hyperglycemia, with long-term current use of insulin. Record review of the MDS with an ARD of 9/2/26 revealed that the BIMS score of 15, indicating that the resident was cognitively intact.	F0760		