

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/20/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255161	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2025
NAME OF PROVIDER OR SUPPLIER NMMC BALDWIN NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 739 4TH STREET SOUTH BALDWIN, 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 MS# 28265, CI MS #28506, and CI MS #28530) at the facility on 04/29/25 through 04/30/25. During the survey the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services. The SA identified non-compliance and cited F656, F677, and F684 for CI MS #28265 and CI MS #28506. The SA investigated CI MS #28530 regarding proper drug storage and cited F761.	F 000			
F 656 SS=D	The census at the time of the survey was 105 and they held a license for 107 beds. Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		6/17/25	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/12/2025

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 656	Continued From page 1 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, record review, and facility policy review the facility failed to implement care plans for a dependent resident with a negative pressure wound therapy system (wound vac) in place and who required assistance with Activities of Daily Living for one (1) of four (4) residents sampled. Resident #1. Findings Include: Review of the facility policy, "Care Plan Policy" with reviewed date of 10/20 revealed, "It is the	F 656	1. Resident number 1 care plan was reviewed by the Director of Nursing (DON) and Minimum Data Set (MDS) Coordinator. A comprehensive care plan was implemented by the DON and MDS Coordinator to include activities of daily living (ADL) and wound care consistent with the residents care needs on 5/1/25. 2. All residents of the facility have the potential to be affected by this practice. All residents were rounded on by Nursing Leadership to ensure all comprehensive care plans were being met and		

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F 656	Continued From page 2 policy of (Proper Name Facility) that care plans should be properly developed and implemented. Record review of Resident #1's "Care Plan" updated 04/11/25 revealed that she required assistance with ADL's (activities of daily living) related to End Stage Renal Disease on dialysis, Decreased Mobility, and Generalized Weakness. Resident #1's Care Plan Approaches included, "to provide appropriate level of assistance with ADL's as needed" and this included limited to extensive need for one person assistance with dressing. Record review of Resident #1's "Wound/Skin Careplan" dated 03/29/25, revealed that she had a surgical wound to her left upper forearm with interventions that included to "apply wound vac at 120 mmHg (millimeters of mercury) continuous." Record review of Resident #1's "Nursing Orders" revealed a wound care order with a start date of 03/31/25 for every Monday, Wednesday, and Friday. The order was to cleanse surgical incision to left upper arm with dermal wound cleanser, pat dry with 4x4 gauze, apply black foam to wound bed only, apply Tegaderm, apply wound vac at 120 mm continuous. Record review of Resident #1's "Nursing Orders" revealed an unscheduled PRN (As Needed) wound care order with start date of 03/31/25. The order was to cleanse surgical incision to left upper arm with dermal wound cleanser, pat dry with 4x4 gauze, and apply NS (normal saline) wet to dry dressing. On 04/29/25 at 9:47 AM, an interview with complainant revealed that Resident #1 had been at the facility for a little over a year. She revealed	F 656	implemented. This was completed by 5/9/25. 3. An in-service education will be conducted by the DON with all direct care staff starting 5/1/25, addressing the significance of developing and implementing a comprehensive person-centered care plan for each resident, consistent with the residents' rights completed by 5/22/25. 4. Nursing Leadership and MDS staff started screening 5 residents to include resident number 1 on 5/1/2025 and will continue to screen five residents weekly for one month (May), then every two weeks for one month (June) and once monthly (July) to ensure all comprehensive care plans are being followed. The results based from verbal exit from the Complaint Survey were reported to the Quality Assurance and Performance Improvement (QAPI) Committee on May 7th, 2025. 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 next QAPI committee meeting on June 17th, 2025, and ongoing.		

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F 656	Continued From page 3 that she had declined since admission into the facility and was now more dependent on the staff for her care. She revealed that on several occasions, Resident #1 had the same clothes on she had worn to dialysis the day before. The complainant revealed that Resident #1 slept in her clothes frequently and she had witnesses that also observed this. She revealed that Resident #1 didn't live like that, she didn't sleep in her clothes at night before she came to the facility, and she shouldn't have to now. The complainant revealed that Resident #1 had pajamas and gowns, and there was no reason she should have to sleep in her regular clothes. She stated, "This is not comfortable for her." She revealed that she reported it to the previous administrator several times and it was never taken care of. An interview on 04/29/25 at 10:00 AM with the complainant revealed Resident #1 recently had an infected fistula removed from her left arm and she had the wound vac in place. She revealed that she had a concern with the nurses not keeping the wound vac hooked up to suction all the time like they were supposed to. Complainant also revealed that Resident #1 had a wound vac (negative pressure wound therapy system) that was supposed to be hooked to suction at all times and the staff knew that. She also revealed that several times last week, she noticed the wound vac was not on and she reported it to the nurse. An observation on 04/29/25 at 3:15 PM revealed Resident #1 reclined back in her wheelchair in the Sunroom with other residents present. She was dressed in a purple top, a brown cardigan sweater, a pair of pants and shoes. Her wound vac tubing was attached to the dressing to her left upper arm and there was no negative pressure	F 656			

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F 656	Continued From page 4 suction applied and no canister in place. An observation on 04/29/25 at 3:30 PM in Resident #1's room, revealed the wound vac pump located in the corner of the room, it was attached to a pole and was not plugged in. Resident #1 was not in her room. An observation on 04/29/25 at 4:40 PM in the dining room revealed Resident #1 sitting up in her wheelchair. The wound dressing to her left upper arm was intact with the wound vac tubing attached and there was no negative pressure suction hooked to it. On 04/30/25 at 9:15 AM, an interview with complainant, revealed that Resident #1 had the same clothes on this morning that she wore to her doctor's appointment yesterday, 04/29/25, a purple shirt and a brown cardigan sweater. On 04/30/25 at 9:30 AM, an observation and interview with Resident #1, revealed her lying in her bed in her room. She had a purple top and a brown colored cardigan sweater on. Resident #1 confirmed that she had the same clothes on that she wore to her doctor's appointment the day before and revealed that the aides did not change her clothes before she went to bed last night. Resident #1 confirmed that she didn't like to sleep in her regular day clothes and that she would rather sleep in her bed clothes, her pajamas or gowns and stated, "But I wasn't asked." An interview on 04/30/25 at 10:40 AM with the Restorative Certified Nursing Assistant (CNA), revealed nearly every day she observed that Resident #1 was in the same clothes from the day before.	F 656			

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F 656	Continued From page 5 During an interview with Resident #1 on 04/30/25 at 10:45 AM with Interim Director of Nursing (DON) present, Resident #1 revealed that they did not change her clothes last night before putting her in bed. Resident #1 confirmed that regular clothes were not comfortable to sleep in and that she liked to sleep in her pajamas. Interim DON confirmed that the CNAs knew it was their responsibility to get the resident clothes changed for bed and to put appropriate bed clothes on them. An interview on 04/30/25 at 9:02 AM, an interview with Registered Nurse (RN) #1, revealed that Resident #1 was supposed to have her wound vac in use and turned on to suction at all times. She revealed that the wound vac had a battery pack and was supposed to be taken with her to appointments as well. RN #1 revealed that not having the wound vac on and running yesterday was a failure on her part. She revealed that not following the physician orders for continuous negative pressure could cause the fluid to pool, it could prevent the wound from healing and could lead to infection. RN #1 stated, "It is doing her (Resident #1) a disservice by not having the wound vac in place as it is ordered." RN #1 confirmed that the wound vac canister should always be attached and hooked to suction unless a wet to dry dressing was applied. She revealed that Resident #1 never complained about discomfort with the wound vac and never refused to have it on, it was just not done. An interview on 04/30/25 at 8:50 AM with Treatment Nurse revealed that Resident #1's wound vac was supposed to be on at all times and hooked to suction. She revealed that a wet	F 656			

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F 656	Continued From page 6 to dry dressing should be applied to the wound site if the wound vac was off and that the wound vac tubing and dressing should never be left on if not hooked to suction. She revealed that Resident #1 went to dialysis every Monday, Wednesday, and Friday and if the wound vac did not go with her, they should apply a wet to dry dressing until she returned. Treatment Nurse revealed that she had noticed the wound vac tubing and dressing on without being hooked to suction several times and had reported it to the Interim Administrator. She revealed that the wound to Resident #1's left arm was much improved, and she could probably get the wound vac discontinued soon. Treatment Nurse revealed that Resident #1 had her dialysis fistula removed about a month ago, she received antibiotics, and the wound vac was placed. An interview on 04/30/25 at 9:05 AM with the Interim Director of Nursing, revealed that it had been brought to her attention by a family member before that the wound vac was not hooked up to suction. She revealed that the wound vac had a battery pack, was portable and there's no reason for it not to be hooked to suction. She revealed that it was the Floor Nurse's responsibility to ensure the wound vac was hooked to suction as ordered. On 04/30/25 at 10:15 AM, an interview with the Minimum Data Set (MDS) Coordinator, revealed that the purpose of the care plan was to provide information on each individual resident for the nurses and cnas to relate back to in order to know how to take care of the specific needs of each resident. She revealed that the comprehensive care plan was a patient directed individualized care approach developed so the	F 656			

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F 656	Continued From page 7 staff know how to take care of each resident. She confirmed that since Resident #1's wound vac was not hooked to suction and since the staff did not change her clothes for bed, and she was left in the same clothes from the day before, her care plans were not followed. Record review of Resident #1's "Medical Record" revealed the most recent admission date of 04/11/24 post hospitalization. She had diagnoses that included Type 2 Diabetes Mellitus with hypertension and ESRD (End Stage Renal Disease) on dialysis, Impaired mobility and ADLs (Activities of Daily Living), and Abscess of Left Upper Extremity. Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 04/17/25 revealed under Section C a Brief Interview for Mental Status (BIMS) Score of 4 which indicated that she had severe cognitive deficits. Record review of Resident #1's MDS with ARD of 04/17/25 revealed under Section GG-Functional Abilities that she was dependent on staff for care that included personal hygiene, dressing upper and lower body.	F 656			
F 677 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 observation, interview, record review	F 677	1) On 4/30/25 resident number 1	6/17/25	

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F 677	Continued From page 8 and facility policy review the facility failed to provide a dependent resident with assistance to change clothes prior to going to bed for one (1) of four (4) residents reviewed. Resident #1. Findings Include: Review of the facility policy "AM/PM Care" dated March 2020 revealed, ".....Resident's clothing should be changed daily and when soiled." On 04/29/25 at 9:47 AM, an interview with the complainant at the facility revealed that Resident #1, had been at the facility for a little over a year. She revealed that she had declined since admission into the facility and was now more dependent on the staff for her care. Activities Director revealed that she came into the facility one Saturday morning and found that Resident #1 had the same clothes on she had worn to dialysis the day before. She revealed that Resident #1 slept in her regular clothes frequently and she had witnesses that also observed this. She revealed that Resident #1 didn't live like that, she didn't sleep in her clothes at night before she came to the facility, and she shouldn't have to now since Resident #1 had pajamas and gowns. She revealed that she reported it to the previous administrator several times and it was never taken care of. She revealed that the facility was Resident #1's home, and it wasn't right to be treated in this manner. An observation on 04/29/25 at 3:15 PM of Resident #1, revealed Resident #1 reclined back in her wheelchair in the Sunroom with other residents present. She was dressed in a purple top, a brown cardigan sweater, a pair of pants and shoes.	F 677	Activities of Daily Living (ADL) care were given to include dressing and personal hygiene by the Charge Nurse. 2) All residents have the potential for the same deficient practice. All other residents rounds were completed on 4/30/25 by the Director of Nursing (DON) to ensure ADL care is given to prevent any care deficiencies, to include dressing and personal hygiene. 3) Employees will be in-serviced by the DON starting by 5/1/25 and completed by 5/22/25 to ensure the proper ADL care for residents to include dressing and personal hygiene. 4) The Nursing Leadership Team started rounds (5/1/25) and will round on facility residents to ensure proper ADL care weekly for one month (May), then every two weeks for one month (June), and once monthly (July). Nursing Leadership started screening 5 residents on 5/1/2025 and will continue to screen five residents weekly for one month (May), then every two weeks for one month (June) and once monthly (July) to ensure proper ADL care is being provided. The results based from verbal exit from the Complaint Survey were reported to the Quality Assurance and Performance Improvement (QAPI) Committee on May 7th, 2025. 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 next QAPI committee meeting on June		

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F 677	Continued From page 9 On 04/30/25 at 9:15 AM, an interview with the complainant revealed that Resident #1 had the same clothes on this morning that she wore to her doctor's appointment yesterday, 04/29/25. She revealed that Resident #1 returned from her appointment yesterday between 11:30 AM and 12:00 PM and came to the dining room to eat with a purple shirt and a brown cardigan sweater. On 04/30/25 at 9:25 AM, an observation revealed Resident #1 lying in bed in her room and she was being assisted with breakfast by a staff member. On 04/30/25 at 9:30 AM, an observation and interview with Resident #1, revealed her lying in her bed in her room. She had a purple top and a brown colored cardigan sweater on. Resident #1 confirmed that she had the same clothes on that she wore to her doctor's appointment the day before and revealed that the aides did not change her clothes before she went to bed last night. Resident #1 confirmed that she didn't like to sleep in her regular day clothes and that she would rather sleep in her bed clothes, her pajamas or gowns and stated, "But I wasn't asked." On 04/30/25 at 10:35 AM, an interview with Registered Nurse (RN) #1, revealed that Resident #1 was confused at times, had declined and she could no longer assist herself to bed. RN #1 revealed that Resident #1 required more help to get her clothes changed and ready for bed. She also revealed that she had told staff multiple times to change residents' clothes before helping them to bed. RN #1 revealed that the Certified Nursing Assistants (CNAs) knew they were responsible for getting the residents ready for bed at night and knew better than to make them sleep in their regular day clothes.	F 677	17th, 2025, and ongoing.		

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F 677	Continued From page 10 An interview on 04/30/25 at 10:40 AM with Restorative Certified Nursing Assistant (CNA), revealed that she came in early every morning and nearly every day she observed that Resident #1 was in the same clothes from the day before. During an interview with Resident #1 on 04/30/25 at 10:45 AM with Interim Director of Nursing (DON) present, Resident #1 revealed that they did not change her clothes last night before putting her in bed and confirmed that the staff didn't offer to help her change into her bed clothes. Resident #1 confirmed that regular clothes were not comfortable to sleep in and that she liked to sleep in her pajamas. She revealed that lately she has had to sleep in her regular clothes every night and stated, "We don't know no better, we just do it." The Interim DON reassured Resident #1 that she would take care of the issue with the staff. Interim DON revealed that this facility was the residents' home, and they should be able to choose what they wanted to sleep in, and their wishes should be granted. Interim DON confirmed that the CNAs knew it was their responsibility to get the resident clothes changed for bed and to put appropriate bed clothes on them. Record review of Resident #1's "Medical Record" revealed the most recent admission date of 04/11/24 post hospitalization. She had diagnoses that included Type 2 Diabetes Mellitus with hypertension and ESRD (End Stage Renal Disease) on dialysis, Impaired mobility and ADLs (Activities of Daily Living), and Abscess of Left Upper Extremity. Record review of Resident #1's Minimum Data	F 677			

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F 677	Continued From page 11 Set (MDS) with Assessment Reference Date (ARD) of 04/17/25 revealed under Section C a Brief Interview for Mental Status (BIMS) Score of 4 which indicated that she had severe cognitive deficits. Record review of Resident #1's MDS with ARD of 04/17/25 revealed under Section GG-Functional Abilities that she was dependent on staff for care that included personal hygiene, dressing upper and lower body.	F 677			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to provide treatment consistent with professional standards of practice to an existing surgical wound for one (1) of three (3) residents reviewed for wound care. Resident #1. Findings Include: Review of the facility policy "Negative Pressure Wound Therapy System, Single Use" dated 03/03/2025 revealed ".....The pump may be disconnected from the dressing if there is a	F 684	1) On 4/30/25 resident number 1s wound care consistent with appropriate quality of care was ensured and carried out by the Director of Nursing (DON), treatment nurse, and hall nurse. 2) All residents have the potential for the same deficient practice. All other residents rounds were completed on 4/30/25 by the treatment nurse to ensure care is given to prevent wound care deficiencies with professional standards of practice to an existing surgical wound. 3) Employees will be in-serviced by the	6/17/25	

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F 684	Continued From page 12 requirement to disconnect - such as the need to have a shower...." An interview on 04/29/25 at 10:00 AM with the complainant revealed that Resident #1, recently had an infected fistula removed from her left arm and she had a wound vac in place. The complainant revealed that she had a concern with the nurses not keeping the wound vac hooked up to suction all the time like they were supposed to. She revealed that Resident #1 went out to a doctor's appointment this morning and did not have the wound vac canister with her when she left. The complainant revealed that there had been several days that she observed that the wound vac was not hooked up to her, she told the nurse, and they sometimes hooked it up and sometimes they did not. She stated, "How is her wound going to heal if they won't do their job and keep it hooked up?" She revealed that she shouldn't have to remind them to do their job. An observation on 04/29/25 at 3:15 PM in the Sunroom revealed Resident #1 reclined back in her wheelchair. Her wound vac tubing was attached to the dressing to her left upper arm and there was no negative pressure suction applied and no canister in place. The complainant revealed that Resident #1 returned from her doctor's appointment around 12:00 PM and went to the dining room and ate lunch. The complainant also revealed that Resident #1's wound vac was left off while she was out to her doctor's appointment, she returned to eat lunch and was now in the Sunroom with other residents and stated, "Her wound vac has not been on all day." She revealed that the wound vac was supposed to be hooked to suction at all times and the staff knew that. She also revealed that	F 684	DON starting 5/1/25 and completed by 5/22/25 to ensure proper wound vac operations and treatment of proper wound care is consistent with professional standards. The Nursing Leadership Team started rounds (5/1/25) and will round on facility residents to ensure proper wound care weekly for one month (May), then every two weeks for one month (June), and once monthly (July). 4) Nursing Leadership started screening 5 residents to include resident number 1 with wound care on 5/1/2025 and will continue to screen five residents weekly for one month (May), then every two weeks for one month (June) and once monthly (July) to ensure all wound care is given to align with professional standards of quality of care. The results based from verbal exit from the Complaint Survey were reported to the Quality Assurance and Performance Improvement (QAPI) Committee on May 7th, 2025. 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 next QAPI committee meeting on June 17th, 2025, and ongoing.		

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F 684	Continued From page 13 several times last week, she noticed the wound vacuum was not on and she reported it to the nurse. An observation on 04/29/25 at 3:30 PM in Resident #1's room, revealed the wound vac pump located in the corner of the room, it was attached to a pole and was not plugged in. Resident #1 was not in her room. An observation on 04/29/25 at 4:40 PM in the dining room revealed Resident #1 sitting up in her wheelchair. The wound dressing to her left upper arm was intact with the wound vac tubing attached and there was no negative pressure suction hooked to it. An interview on 04/30/25 at 9:02 AM, an interview with Registered Nurse (RN) #1, revealed that Resident #1 was supposed to have her wound vac in use and turned on to suction at all times. She revealed that the wound vac had a battery pack and was supposed to be taken with her to appointments as well. RN #1 revealed that not having the wound vac on and running yesterday was a failure. She revealed that not following the physician orders for continuous negative pressure could cause the fluid to pool, it could prevent the wound from healing and could lead to infection. RN #1 stated, "It is doing her (Resident #1) a disservice by not having the wound vac in place as it is ordered." RN #1 confirmed that the wound vac canister should always be attached and hooked to suction unless a wet to dry dressing was applied. She revealed that Resident #1 never complained about discomfort with the wound vac and never refused to have it on, it was just not done.	F 684			

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F 684	Continued From page 14 An interview on 04/30/25 at 8:50 AM with Treatment Nurse, revealed that Resident #1's wound vac was supposed to be on at all times and hooked to suction. She revealed that a wet to dry dressing should be applied to the wound site if the wound vac was off and that the wound vac tubing and dressing should never be left on if not hooked to suction. She revealed that Resident #1 went to dialysis every Monday, Wednesday, and Friday and if the wound vac did not go with her, they should apply a wet to dry dressing until she returned. Treatment Nurse revealed that she had noticed the wound vac tubing and dressing on without being hooked to suction several times and had reported it to Interim Administrator herself. She revealed that the wound to Resident #1's left arm was much improved, and she could probably get the wound vac discontinued soon. Treatment Nurse revealed that Resident #1 had her dialysis fistula removed about a month ago, she received antibiotics, and the wound vac was placed. An interview on 04/30/25 at 9:05 AM with Interim Director of Nursing, revealed that it had been brought to her attention by a family member before that the wound vac was not hooked up to suction. She revealed that the wound vac had a battery pack, was portable and there's no reason for it not to be hooked to suction. She revealed that it was the Floor Nurse's responsibility to ensure the wound vac was hooked to suction as ordered. Interim DON revealed that they had an order for continuous suction and an as needed order for a wet to dry dressing to be applied if wound vac was malfunctioning. Interim DON revealed that leaving the wound vac paused and not hooked up to suction all day was a big problem, she revealed that the wound could	F 684			

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F 684	Continued From page 15 become infected and stated, "the risk is there." Interim DON clarified the PRN (as needed) physician order for the wet to dry dressing and revealed that the wet to dry dressing was supposed to be applied to the surgical wound if the wound vac became dislodged, displaced, or if any problem occurred with the wound vac and she revealed that she would update the order. An interview on 04/30/25 at 10:40 AM with Nurse Practitioner (NP), revealed that Resident #1's wound vac was supposed to be hooked to suction at all times with the exception of one to two hours. If needed. She revealed that if the wound vac was planned to be unhooked from suction for longer than two hours, a wet to dry dressing was supposed to be put on. NP revealed that not appropriately utilizing the wound vac for Resident #1 could cause worsening of the wound because without suction, the fluids would pool and not get suctioned off which could lead to infection or deterioration of the wound. She revealed that the nurses on the hall should be keeping a check on the wound vac's and ensuring they functioned properly and that they were hooked up to suction while in use. An interview on 04/30/25 at 9:15 AM with complainant revealed that Resident #1 returned from her doctor's appointment yesterday between 11:30 AM and 12:00 PM and went straight to the dining room to eat lunch, and Resident #1's wound vac dressing and tubing was in place to her left arm but the wound vac canister with suction was left off. The complainant stated that Resident #1 participated in an activity at 2:00 PM yesterday, then went into the Sunroom with other residents and revealed that the wound vac was still not hooked to suction.	F 684			

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F 684	Continued From page 16 Record review of Resident #1's "Nursing Orders" revealed a wound care order with a start date of 03/31/25 for every Monday, Wednesday, and Friday. The order was to cleanse surgical incision to left upper arm with dermal wound cleanser, pat dry with 4x4 gauze, apply black foam to wound bed only, apply Tegaderm, apply wound vac at 120 mmHg continuous. Record review of Resident #1's "Nursing Orders" revealed an unscheduled PRN (As Needed) wound care order with start date of 03/31/25. The order was to cleanse surgical incision to left upper arm with dermal wound cleanser, pat dry with 4x4 gauze, and apply NS (normal saline) wet to dry dressing. Record review of Resident #1's "Wound/Skin Care Plan" dated 03/29/25, revealed that she had a surgical wound to her left upper forearm with interventions that included "apply wound vac at 120 mmHg (millimeters of mercury) continuous." Record review of Resident #1's "Medical Record" revealed the most recent admission date of 04/11/24 post hospitalization. She had diagnoses that included Type 2 Diabetes Mellitus with hypertension and ESRD (End Stage Renal Disease) on dialysis, Impaired mobility and ADLs (Activities of Daily Living), and Abscess of Left Upper Extremity. Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 04/17/25 revealed under Section C a Brief Interview for Mental Status (BIMS) Score of 4 which indicated that she had severe cognitive deficits.	F 684			

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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 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 interview, record review and facility policy review, the facility failed to properly store medications needing refrigeration in one (1) of two (2) medication storage rooms. Station one (1) Medication Storage Room. Findings Include: Review of the facility policy, "Medication Storage" with last modified date of 03/14/2024, revealed,	F 761	1)An immediate investigation by the Baldwin Leadership team was conducted at the time of the incident on 4/6/25-4/9/25. It was self-reported in good faith to the Mississippi Department of Health (MSDH) on 4/6/2025. The facility purchased another dorm refrigerator to house medications along with a lock box. This was confirmed by the surveyor onsite on 4-30-25.	6/17/25	

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F 761	Continued From page 18 "It is the policy of (proper name) that all medications should be appropriately delivered and stored." The policy also revealed under "Security and Storage" that "....Once the medications are removed from the designated storage area, the medications should remain with the licensed designated individual at all times and should not be left unattended...." An interview on 04/29/25 at 10:55 AM with Interim Director of Nursing (DON), revealed that they had a small refrigerator in each medication room with a lock box inside where they kept their narcotics that required refrigeration. She revealed that on 04/03/25, Licensed Practical Nurse (LPN) #1 was defrosting one of the medication refrigerators and realized that there was a problem with it. Interim DON revealed that the nurses normally emptied their refrigerators of any medications and locked the medications in the medication carts until the defrosting process was completed. Interim DON revealed that LPN #2 went and retrieved one of the vials of Ativan injectable out of the refrigerator for one of her residents, and left four vials in the locked box inside the refrigerator. Interim DON revealed that LPN # 1 was under the impression that LPN #2 removed all five vials of the Ativan from the refrigerator. She revealed that when the charge nurse realized that the refrigerator was not working properly, she took it out back to have maintenance check it out to see if it needed parts to repair or if it needed to be replaced. The Interim DON revealed that when LPN #2 came back to work, she realized that the refrigerator was gone and then remembered the four vials of Ativan that were left in there. The Interim DON revealed that when they realized the situation, they contacted her (Interim DON) and Interim Administrator, and they wondered where the	F 761	2)All residents of the facility have the potential for the same deficient practice. 3)An in-service education was started on 5/1/2025 being conducted by the Director of Nursing (DON), with all nursing staff to address proper medication storage and administration. This will be completed by 5/22/2025. This education will continue to be included in our new hire orientation with all nursing staff as well. 4)Beginning 5/1/2025 Baldwin Nursing Leadership comprised of the DON, Minimum Data Set (MDS) Coordinator and Infection Control/Admissions Nurse will conduct medication cart and medication refrigerator audits weekly for one month (May), then every two weeks for one month (June) and once monthly (July) 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 May 7th, 2025. 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 next QAPI committee meeting on June 17th, 2025, and ongoing.		

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F 761	Continued From page 19 refrigerator went. Interim DON revealed that they investigated the situation and found that the refrigerator had been transported as scrap to the landfill, and they were not allowed to retrieve it. She revealed that each lock box they kept in the refrigerators had a key that the nurses kept and were not easily accessed. She revealed that on the night this occurred, LPN #2 should have removed all of the Ativan from the refrigerator and locked it up in the medication cart until LPN #1 finished defrosting it. Interim DON revealed that the vials of Ativan were accounted for at end of shift, and it was the next day, they discovered that they were gone. An interview on 04/29/25 at 11:20 AM with Interim Administrator, revealed that they had a refrigerator in one of the medication rooms that malfunctioned, and it was placed on the back dock to be disposed of. Interim Administrator revealed that due to failed communication on the nurses' part, four vials of Ativan were left inside the locked box in the refrigerator, and it was taken as scrap to a landfill and there was no way to get it back. He confirmed that the four vials of Ativan should have been removed from the refrigerator and locked up prior to placing the refrigerator outside to ensure no one else had access to the medication. A phone interview on 04/29/25 at 5:12 PM with LPN #1, revealed that she was working on the night shift of 04/03/25. She revealed that she noticed some water leakage onto the insulin labels and some ice buildup in the refrigerator that was located in the medication storage room at Nursing Station 1. LPN #1 revealed that she took the refrigerator to the shower room to defrost it. She revealed that she knocked the ice off of it	F 761			

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F 761	Continued From page 20 and when she plugged it back up, she heard a hissing sound, and she smelled some kind of chemical. LPN #1 revealed that she took the refrigerator out on the back dock to be checked out by maintenance to see if it needed parts ordered or if it needed to be replaced. LPN #1 revealed that the refrigerator in the medication storage room at Nursing Station 1 held lock boxes for halls A, B, and C. She revealed that she had removed the Hall C locked box, and the nurse locked it up in the medication cart. She revealed that there were no medications in the Hall A locked box and that LPN #2 came in while she was defrosting the refrigerator to get Ativan from the Hall B locked box. LPN #1 revealed that this was where the miscommunication came in. LPN #1 revealed that she thought LPN #2 removed all of the Ativan from the refrigerator from Hall C locked box, but she only got one vial of the Ativan for a resident who needed it right then. LPN #1 revealed that they found out the next day that the maintenance guy took the refrigerator off before the narcotic boxes (A and B) were removed. She revealed that the maintenance man didn't know they were in there either. LPN #1 revealed that she should have made sure that all locked boxes and narcotics were removed from the refrigerator before taking it outside and she should not have assumed that LPN #2 had removed them. She confirmed that the medications were not properly stored during that time, and she agreed that leaving the Ativan in the unattended refrigerator was a risk for someone else taking the medications. A phone interview on 04/29/25 at 5:30 PM with LPN #2, revealed that she worked on April 3, 2025, on the night shift. She revealed that on that night, she needed to get a dose of Ativan out of	F 761			

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(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 761	Continued From page 21 the refrigerator for one of her residents. She revealed that LPN #1 had the refrigerator in the shower room defrosting it, LPN #2 got one vial of Ativan out and left the other four vials of Ativan in there. LPN #2 revealed that LPN #1 said something about the refrigerator, but she thought LPN #1 would put it back in the medication storage room when she finished defrosting it until maintenance could check it out. LPN #2 revealed that it was miscommunication and if she had known that there was a problem with the refrigerator or that it was going to be taken out back, she would have removed all narcotics and locked them up in the medication cart to make sure they were secure. LPN #2 revealed that keeping up with the narcotics was a serious issue and she hated that it happened and agreed that all medications should be properly secured and locked up to prevent them from falling in the wrong hands. Record review of LPN #1's "Statement" revealed, "I was defrosting refrigerator due to ice buildup and when I plugged it back in, I heard a hissing noise that smelled like chemicals. I was transporting the refrigerator outside for ventilation and I gave C hall their narcotics from narcotic box, then B hall nurse (proper name) (LPN #2) came up and said she needed to get hers out for B hall. I was not aware that nurse only got 1 dose out. I took refrigerator to back door and sat outside "The next I heard about it was when (proper name of LPN #2) came to me Saturday night and asked where the fridge was. I looked where I put it and it was gone. DON made aware at this time." Statement was signed by LPN #1 on 04/08/25. Record review of LPN #2's "Statement" revealed,	F 761			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 761	Continued From page 22 "On April third, 2025 I needed to retrieve an Ativan vial from the Station 1 refrigerator, the charge nurse (proper name for LPN #1) was defrosting the refrigerator in the Station 1 shower room, I retrieved the needed vial and replaced the remaining vials back into the refrigerator narcotic lockbox. During April third shift change I had not been informed that the Station 1 refrigerator had been moved from Station 1 med room and believed that it was still on the premises." The statement was signed by LPN #2 on 04/08/25. Record review of the "Controlled Substance Record" form revealed there were five vials of Ativan 2 mg/ml in the refrigerator for a resident on B Hall. The record revealed documentation of one vial of Ativan 2 mg/ml signed out on 04/03/25 at 02:58 by LPN #2 with four vials left. Record review of LPN #1 and LPN #2's "Time Card Report" revealed that they worked on the night shift of 04/02/25 to the morning of 04/03/25. Record review revealed that LPN #1 clocked in on 04/02/25 at 18:36 and clocked out on 04/03/25 at 07:29. LPN #2 clocked in on 04/02/25 at 18:42 and clocked out on 04/03/25 at 07:10 The misplaced 4 vials of Ativan 2 mg/ml for resident on B Hall were credited to the resident's account.	F 761			