MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41NM	A. BUILDING: _____ B. WING _____	C 04/30/2025

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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted Complaint Investigations (CI MS# 28265, CI MS #28506, and CI MS #28530) at the facility on 03/25/25 through 03/26/25. During the survey the SA determined that the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm. The SA identified non-compliance and cited M610 and M655 for CI MS # 28265. The SA investigated CI MS #28506 and CI MS #28530 with no deficiencies cited. The census at the time of the survey was 105 and they held a license for 107 beds.	M 000		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Based on observation, interview, record review 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	M 610	1) On 4/30/25 resident number 1 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	6/17/25

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M 610	Continued From page 1 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. The complainant 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. 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.	M 610	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 17th, 2025, and ongoing.	

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M 610	Continued From page 2 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. 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	M 610		

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M 610	Continued From page 3	M 610		

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 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.

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M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute 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 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	M 655	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 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	6/17/25

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M 655	Continued From page 5 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 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.	M 655	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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M 655	Continued From page 6 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. 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	M 655		

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M 655	Continued From page 7	M 655		

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 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

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M 655	Continued From page 8 #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. 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	M 655		

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M 655	Continued From page 9 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.	M 655		