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 11/04/2025

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 two (2) onsite complaint investigations (CI) MS# 2598812 and CI MS# 2652123 at the facility from 11/3/25 through 11/4/25. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid for complaint CI MS# 2652123 and cited F 684 and F 686. The SA investigated CI MS# 2598812 with no deficiencies cited. The SA investigated allegations related to Abuse, Quality of Care, Staffing, Activities of Daily Living, and Accidents. The census at the time of the survey was 102 and the facility is licensed for 107 beds.	F0000		
F0684 SS = G	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, resident and staff interviews, record review, and facility policy review, the facility failed to ensure skin care treatments were completed as ordered for one (1) of three (3) residents reviewed for wound and skin care. This deficient practice resulted in deterioration of a resident's wound, including a significant increase in wound size for Resident #1. Findings include: Review of the facility policy titled "Skin and Wound Care," last reviewed 5/2/24, revealed: "Policy: It is the policy that skin anomalies should be identified, and basic wound care should be provided."	F0684		

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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F0684 SS = G	Continued from page 1 Resident #1 During an onsite complaint survey, an interview with Resident #1 on 11/3/25 at 10:30 AM revealed she had wounds to her legs. Resident #1 stated she often does not get her dressing changed to her leg at night and sometimes during the day. Observation revealed a dressing to the left posterior leg. Review of wound care orders for Resident #1's left lower leg ulcer revealed orders dated 9/20/25, 10/14/25, and 10/22/25, with treatment intervals of two (2) times daily. Review of Resident #1's October/November 2025 Treatment Flow Sheet for the left lower posterior leg ulcer revealed the treatment was not documented as completed as ordered thirty-five (35) times from 10/1/25 through 11/3/25 for the second dressing change daily. Review of the Weekly Skin Summary report dated 9/2/25 for Resident #1 revealed the left lower posterior leg ulcer measured 12 cm (centimeters) x 6.2 cm x 0.1 cm. State of healing: worsening. Review of the Weekly Skin Summary report dated 11/4/25 for Resident #1 revealed the left lower posterior leg ulcer measured 21.5 cm x 8 cm x 0.1 cm. State of healing: worsening. This represents a significant increase in wound size over the two-month period. An observation of Resident #1 on 11/4/25 at 8:54 AM with the treatment nurse revealed a saturated, intact dressing dated 11/3/25 at 9:25 AM, with a large area of dried drainage noted on the resident's pillowcase under the left leg dressing. The treatment nurse confirmed that was the dressing she applied on 11/3/25, verified by her initials. She stated the order was for the treatment to be completed twice daily and confirmed Resident #1's left leg ulcer had worsened over the last month. She also confirmed the dressing was soiled with drainage and the pillowcase as well. In a continued interview with the Treatment Nurse on 11/4/25 at 9:05 AM, she stated that she had recently found wound dressings on residents that had not been changed as ordered and had reported these findings to the Director of Nursing (DON). The Treatment Nurse explained that failure to perform wound care as ordered could cause wounds to worsen or become infected. She stated she performs treatments during the day, Monday through Friday, and that night shift and weekend nurses are responsible for completing their own wound	F0684		

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F0684 SS = G	Continued from page 2 treatments if a wound order dressing change is for more than one time a day. She further stated that when a treatment nurse is not scheduled, the assigned nurses are responsible for completing all wound treatments for their residents. Review of the demographic sheet for Resident #1 revealed the facility admitted the resident on 1/01/25 with a diagnosis of diabetic venous ulcers of both lower legs, lower extremity edema and Stage 3 chronic kidney disease. Record review of Resident #1's Section C of the Quarterly Minimum Data Set (MDS) revealed that on 10/1/25, the Brief Interview for Mental Status (BIMS) score was 13, indicating the resident was cognitively intact. Record review revealed a Medical Doctor progress note dated 08/19/25 that stated, "Vascular surgery did not recommend revascularization due to bedbound and comorbidities. Patient will eventually require left (L) above the knee amputation (AKA)." Record review of wound care center physician order dated 09/20/25 for an order to change dressing from once daily to twice daily (BID). Current treatment order is for left lower leg (LLL) cleanse with normal saline, pat dry with gauze, place Adaptic wound dressing to wound bed, cover with abdominal pad (ABD) and wrap with kerlix BID. An interview with the Assistant DON on 11/4/25 at 11:20 AM confirmed that staff failing to complete wound care as ordered could lead to worsening wounds. An interview with the DON on 11/5/25 at 11:30 AM confirmed she was aware the facility had concerns with treatments not being completed but not to the extent identified. She also stated she was unsure of the reason the wound care was not being completed.	F0684		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F0686		

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F0686 SS = D	Continued from page 3 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to ensure wound care treatments were completed as ordered for two (2) of three (3) residents reviewed for pressure ulcer wound care (Residents #2 and #3). Findings include: Review of the facility policy titled “Skin and Wound Care,” last reviewed 5/2/24, revealed: "Policy: It is the policy that skin anomalies should be identified, and basic wound care should be provided.” Resident #2 An interview with Resident #2 on 11/3/25 at 11:00 AM revealed she had a wound on the back of her right leg. She confirmed there had been a few times over the past month that her treatment had not been completed. Record review of wound care orders for Resident #2’s right upper leg stage (4) pressure injury (PI) revealed orders dated 8/21/25 and 10/20/25, with treatment intervals of daily. Record review of Resident #2’s October/November 2025 Treatment Flow Sheet for the right upper posterior leg revealed the treatment was not completed as ordered five (5) times from 10/1/25 through 11/3/25. Record review of the demographic sheet for Resident #2 revealed the facility admitted the resident on 2/3/25 with a diagnosis of paraplegia. Record review of Resident #2’s Section C of the Minimum Data Set (MDS) revealed that on 8/6/25, the Brief Interview for Mental Status (BIMS) score was 15, indicating the resident was cognitively intact. Resident #3	F0686		

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F0686 SS = D	Continued from page 4 Record review of wound care orders for Resident #3's sacral stage (4) pressure injury revealed orders dated 9/20/25, 10/14/25, and 10/22/25, with treatment intervals of two (2) times daily. Record review of Resident #3's October/November 2025 Treatment Flow Sheet for the sacral stage (4) pressure injury revealed the treatment was not documented as completed as ordered nine (9) times from 10/1/25 through 11/3/25. Record review of the demographic sheet for Resident #3 revealed the facility admitted the resident on 5/14/25 with a diagnosis of metastatic disease in the pelvis and a stage (4) pressure ulcer of the coccygeal region. On 11/4/25 at 11:20 AM, in an interview with the Assistant Director of Nursing (ADON) confirmed that staff failing to complete wound care as ordered could lead to worsening wounds. On 11/5/25 at 11:30 AM, an interview with the Director of Nursing (DON) confirmed she was aware the facility had concerns with treatments not being completed but not to the extent identified. She also stated she was unsure of the reason the wound care was not being completed.	F0686		