Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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
M0000	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 Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm for CI MS# 2652123 and cited M 615. 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.	M0000		
M0615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II 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 (3) residents reviewed for wound care (Resident #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	M0615		

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

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M0615	Continued from page 1 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 MDS revealed that on 8/6/25, the BIMS score was 15, indicating the resident was cognitively intact. Resident #3 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 DON 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 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.	M0615		