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 **03/26/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC BALDWYN NURSING FACILITY	**739 4TH STREET SOUTH , BALDWYN, Mississippi, 38824**

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M0000	Initial Comments The State Agency (SA) conducted an Annual Re-certification survey along with three (3) Complaint Investigations (CI MS #2727095, CI MS #2964262, and CI MS #2802682), at the facility on 3/23/26 through 3/26/26. 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. The SA identified non-compliance and cited M500, M610, M615, M620, M640, M645, M715, and M1570. There were no deficiencies cited for CI # 2727095, CI #2964262, or FRI #2802682. The census at the time of the survey was 100 and the facility is licensed for 107 beds.	M0000		
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as	M0500		

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

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M0500	Continued from page 1 documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be	M0500		

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M0500	Continued from page 2 used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically	M0500		

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M0500	Continued from page 3 contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on record review and staff interviews, the facility failed to ensure informed consent was obtained prior to the initiation of a psychotropic medication for one (1) of two (2) residents reviewed for unnecessary medications. Resident #2 Findings include: Record review revealed the facility had no policy requiring psychotropic consent forms to be obtained prior to initiation of a psychotropic medication. Record review of Resident #2's Active Order Sets revealed an order dated 2/25/26 for Seroquel oral tablet 50 milligrams (mg) to be given by mouth at bedtime for non-Alzheimer's dementia and an order dated 2/25/26 for Buspar oral tablet 10 mg to be given three times daily for depression. Record review revealed the Psychotropic Medication Informed Consent Form was not signed until 3/23/26. On 3/26/2026 at 8:37 AM, during an interview with the Minimum Data Set (MDS) Consultant, she stated there should have been signed consent for Seroquel and Buspar prior to initiation; however, the facility did not obtain consents until approximately one month later. During an interview with the Director of Nursing (DON) on 3/26/2026 at 9:00 AM, she confirmed that the facility had not obtained consents prior to initiation of the psychotropic. Record review of Resident #2's Admission Record revealed the resident was admitted to the facility on 2/25/2026 with diagnoses including Heart Failure, Dementia, Mood Disorder, Anxiety and Depression. Record review of the MDS with an Assessment Reference	M0500		

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M0500	Continued from page 4 Date (ARD) of 3/04/2026 revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident had moderate cognitive impairment.	M0500		
M0610	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 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 Activities of Daily Living (ADL) was provided to residents requiring assistance with personal hygiene for four (4) of the twenty-five sampled residents. (Residents #7, # 10, #46, and #54) Findings include: Record review of facility policy titled, "AM/PM Care" dated 10/24 revealed, "Rationale: to provide guidelines to help promote resident cleanliness. ... Residents should be shaved per preference." Resident #7 During an observation with Resident #7 on 3/23/26 at 11:40 AM, the resident revealed she would like for her fingernails to be trimmed. Observation revealed the resident's fingernails were approximately one-half (1/2) inch in length. The resident was also observed to have dark chin hair approximately one-fourth (1/4) inch in length.	M0610		

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M0610	Continued from page 5 During an observation with Resident #7 on 3/24/26 at 8:39 AM, the resident continued to request that her fingernails be trimmed. Observation revealed long fingernails and visible chin hair that had not been addressed. On 3/26/26 at 8:50 AM, the Director of Nursing (DON), observed and confirmed the resident's fingernails and facial hair. During an interview following the observation, the DON confirmed that the resident should have had her fingernails trimmed and facial hair removed. She stated it is the expectation of the facility that residents' facial hair be groomed, and fingernails be clean and trimmed. Record review of Resident #7's Admission Record revealed the resident was admitted to the facility on 9/16/2025. Record review of Resident #7's "Medical Problems" list revealed diagnoses including functional quadriplegia, muscle spasticity, and ataxia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/24/2025 revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. Resident #10 An observation on 3/23/26 at 10:45 AM revealed Resident #10 lying in bed asleep. The resident was unshaven, and his fingernails were long, with a dark substance under them. The resident was unkempt in appearance. Observation and interview on 3/23/26 at 12:20 PM revealed Resident #10 with facial hair on the sides of his face, on his chin, and neck, approximately one (1) inch long. His fingernails on both hands were approximately one and a half (1 ½) inches (in) long with a dark substance under the nails. The resident's hair was disheveled with a white, flaky substance noted throughout. Resident #10 stated, "I really need to be shaved, and my fingernails are so long. It's been a long time since I've had them done. I really need them cut."	M0610		

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M0610	Continued from page 6 During an observation and interview on 3/24/26 at 8:25 AM, Resident #10's appearance was unchanged from the prior day. Resident #10 stated, "I still haven't been shaved and cleaned up, and these fingernails are so long." Resident #10 stated, "I bet you wouldn't want your fingernails to look like this. I really need to be shaved, and my fingernails cleaned and trimmed." During an interview and observation on 3/24/26 at 11:00 AM, Certified Nurse Aide (CNA) #1 revealed that Resident #10 is scheduled to have his showers on the night shift. She confirmed that the resident required grooming, including shaving and hair washing. During an observation and interview on 3/24/26 at 11:20 AM, the DON confirmed Resident #10 was not adequately groomed. The DON stated, it's primarily the treatment nurse's responsibility to ensure the fingernails are trimmed. During an interview on 3/24/2026 at 11:35 AM, Registered Nurse (RN) #1 confirmed that both residents' fingernails were long and required trimming and stated she was unsure when they had last been addressed. RN #1 further revealed that staff routinely assume she is the only individual responsible for trimming residents' fingernails. She stated that she has voiced concerns to management that, in addition to her other job duties, she is unable to complete nail care for all residents in the facility. Record review of the "Demographics" page revealed Resident #10 was admitted to the facility on 3/16/21. Record review of Resident #10's "Medical Problems" list revealed the resident has diagnoses which include Hemiparesis affecting left side as late effect of cerebrovascular accident (CVA), Peripheral Artery Disease, and Type 2 Diabetes Mellitus. Record review of Resident #10's MDS with ARD of 12/24/25 revealed a BIMS of 15 which indicated the resident was cognitively intact. Resident #46 During an observation and interview with Resident #46	M0610		

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M0610	Continued from page 7 on 3/23/26 at 4:30 PM, the resident revealed she would like for her facial hair to be removed. The observation revealed facial hair under her chin on upper front part of neck. An observation and interview with Resident #46 on 3/24/26 at 8:20 AM revealed resident requested hair to be removed. Observation of light-colored, fine, but thick hair covering the area under her neck on the front portion of upper neck and appeared to be about 1/3 - 1/2 inch long. On 3/24/26 at 8:30 AM, the DON observed and confirmed the resident for her facial hair. During an interview after the observation, the DON acknowledged that each resident should have their ADL care needs met. She confirmed the facility failed to meet this need by not addressing a lady resident with facial care and her preference to have this removed. Record review of the "Demographics" page revealed Resident was admitted to the facility on 7/1/20. Record review of Resident #46's "Medical Problems" list revealed the resident had a diagnosis of Cerebral Infarction. Record review of Resident #46's MDS with ARD of 2/25/26 revealed a BIMS of 15 which indicated the resident was cognitively intact. Resident #54 During an observation and interview on 3/23/26 at 10:50 AM, Resident #54 was observed with approximately one (1) inch of facial hair and fingernails measuring approximately one-half (1/2) inch in length with a dark substance noted underneath. The resident's hair appeared greasy and disheveled, and a noticeable body odor was present. Resident #54 revealed it's been a while since I have been shaved and had my fingernails trimmed. I'm supposed to get my bath tonight. During a follow-up observation and interview on 3/24/26 at 10:00 AM, Resident #54 revealed I was supposed to get a bath last night, but the two CNAs were so busy, and I guess they couldn't get to me. At that time,	M0610		

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M0610	Continued from page 8 Resident #54 continued to present with disheveled, greasy hair, facial hair measuring approximately one (1) inch in length, and fingernails approximately one-half (1/2) inch long with debris present. A noticeable body odor remained. During an interview and observation on 3/24/26 at 11:05 AM, CNA #1 revealed that Resident #54 is scheduled to have his showers on the night shift. She confirmed that the resident required grooming, which includes a bath, shaving, and his hair washed. She revealed it looks like it's been a while since he was cleaned up to which Resident #54 stated, "It's been two weeks." During an interview on 3/24/26 at 11:10 AM, CNA #1 revealed that Resident #10 and Resident #54 were scheduled to receive baths or showers on the night shift on Monday, Wednesday, and Friday, and the bathing or showering includes complete head-to-toe hygiene care, including hair washing and shaving of facial hair as needed. CNA #1 confirmed that Resident #10 and Resident #54 were unkempt and dirty in appearance and stated, “I’m not honestly sure when they were last shaved or when they last had their baths.” CNA #1 additionally revealed that she had reported concerns to upper management on multiple occasions, stating that when the day shift staff arrived, several of the residents who were supposed to receive their baths or showers on the night shift appeared not to have been cleaned or groomed as required. During an observation and interview on 3/24/2026 at 11:25 AM, the DON confirmed that Resident #54 was not adequately groomed and acknowledged that it appeared he had not been shaved in quite some time. Resident #54 stated, "I guess the aides were just too busy to get to me last night." The DON revealed it is our expectation that all of our residents are kept clean and well-groomed. The DON confirmed that the facility failed to adequately meet the resident's ADL needs. Record review of the "Demographics" page revealed Resident #54 was admitted to the facility on 8/21/25. Record review of Resident #54's "Medical Problems" list revealed the resident has diagnoses which include Chronic Obstructive Pulmonary disease, Total self-care deficit, and Traumatic Brain Injury.	M0610		

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M0610	Continued from page 9 Record review of Resident #54's MDS with ARD of 2/18/26 revealed a BIMS of 14, which indicated the resident was cognitively intact.	M0610		
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 record review, facility policy review, and resident and staff interviews, the facility failed to ensure necessary treatment and care were provided to promote healing and prevent worsening of pressure ulcers for one (1) of four (4) residents reviewed for pressure ulcers (Resident #7). 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 #7 An interview with Resident #7 on 3/25/26 at 2:00 PM revealed the resident was admitted with two wounds, one on the buttock and one on the sacrum. The resident stated one wound had healed and the sacral wound remained present. Record review of wound care orders for Resident #7's sacral stage four (4) pressure ulcer with physician orders dated 2/10/2026 with treatment intervals of two (2) times daily. Record review of the Treatment Administration Record (TAR) for March 2025 Flow Sheet for the sacral pressure ulcer revealed the wound care treatments were not completed as ordered on 3/11/26, 3/14/26, and 3/24/26 on the PM shift.	M0615		

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M0615	Continued from page 10 On 3/26/26 at 10:25 AM, during an interview and interview with Registered Nurse (RN) #1, she confirmed the night shift nurse did not complete the wound treatments on the identified dates. Observation and interview with the treatment nurse revealed that the wound care dressing to the sacral on the morning of 03/26/26 was dated the previous day of 03/25/26 and the physician's order had not been completed for the PM wound care dressing change. Record review of wound documentation revealed the resident was admitted with two wounds, the left buttock wound had resolved, and the sacral wound remained present and was healing. On 3/26/26 at 11:05 AM, an interview Director of Nursing confirmed it is the facility's expectation that ordered treatments are completed as prescribed and it could delay the wound care healing process. Record review of Resident #7's Admission Record revealed the resident was admitted to the facility on 9/16/2025. Record review of Resident #7's "Medical Problems" list revealed diagnoses including functional quadriplegia, muscle spasticity, and ataxia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/24/2025 revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact.	M0615		
M0620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II	M0620		

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M0620	Continued from page 11 Based on observation, staff interview, record review, and facility policy review, the facility failed to provide a catheter securement device for a resident with an indwelling catheter for one (1) or four (4) catheters observed. Resident #4 Findings include: Resident #4 Record review of facility letterhead titled "Catheter Care (if present)" dated 3/25/26, revealed "5A. The catheter tubing should be secured with securement device to resident's upper portion of lower extremity (ex. Adhesive securement device, leg securement strap, or other approved device provided by [local hospital])." During an interview and observation of catheter care by Certified Nursing Assistant (CNA) #2 on 3/24/26 at 2:10 PM, it was noted that Resident #4 had an indwelling catheter. It was observed that no securing device was in place for the securement of the catheter. CNA #2 revealed that use of the device was required to secure the catheter in place and this must have fallen off. An interview on 3/24/26 at 2:20 PM with the Director of Nursing (DON) revealed the catheter securing device should be in place for each resident with an indwelling catheter. She confirmed the facility failed to have a securing device in place for the protection of Resident #4's catheter placement. Record review of "Demographics" page for Resident #4 revealed resident was admitted to the facility on 11/6/25. Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 2/11/26 revealed a Brief Interview for Mental Status (BIMS) score of nine (9) which indicated a moderate cognitive impairment.	M0620		
M0640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, record review, staff interview, and facility policy review, the facility failed to ensure adequate supervision and implementation of interventions to prevent accidents for one (1) of four (4) falls reviewed. Resident #65 Findings Include:	M0640		

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NMMC BALDWYN NURSING FACILITY	**739 4TH STREET SOUTH , BALDWYN, Mississippi, 38824**

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M0640	Continued from page 12 Review of the facility policy titled “Fall Prevention and Post Fall Assessment & (and) Follow-up” revealed under, “Rational: To provide guidelines for the identification of residents at risk for falls. To provide assessments, interventions, and documentation after a resident fall.” Also revealed under, “Policy: It is the policy of ‘Proper name of the facility’ to identify residents at risk for falls in the attempt to help prevent falls and resident falls should be handled appropriately.” During an observation outside Resident #65’s room on 3/23/26 at 12:20 PM the door was closed. The resident was located on the window side of the room, and the center privacy curtain was pulled. Resident #65 was lying in bed, awake and non-verbal. The left side of the bed was against the wall and one-half (1/2) side rails were located on the right and left side of the bed. A fall mat was located on the floor. Record review of Resident #65’s “Fall Event” dated 2/17/26 revealed the resident was found on the floor with his head near the feeding pump pole. Record review of Resident #65’s “Fall Event” dated 2/25/26 revealed, “Called to room per staff. Upon entering room, observed resident lying in the floor on side of bed. CNA (certified nurse aide) in room and reported resident rolled off bed while she was providing care.” On 3/24/26 at 2:41 PM, an interview with Licensed Practical Nurse (LPN) #1 revealed Resident #65 was a high risk for falls. She stated on her shift she ensured the bed was in the lowest position and the fall mat was in place. She stated the aides made rounds every 2 hours and the nurses made rounds opposite the aides, resulting in hourly rounding. LPN #1 explained the resident’s roommate would not allow the room door to remain open so that he was visible to staff from the hallway. She revealed the resident was contracted and rocked his body side to side in the bed when he was wet or in pain, which increased his safety risk. Record review of Resident #65’s ADL (activities of daily living) “Task” revealed the resident was total dependence for bed mobility and total dependence with toileting assistance without reference to an amount of staff required. On 3/25/26 at 1:36 PM, an interview with the Registered	M0640		

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M0640	Continued from page 13 Nurse (RN) #3 confirmed that Resident #65's Activity Daily Living (ADL) task indicated he was totally dependent for bed mobility and toileting care but did not specify how many staff were required to perform the task safely. She explained it was a flaw with the charting system, stating that the task could only be set up to indicate total dependence. RN #3 confirmed staff should be aware of how many staff were required to perform the task safely. Record review of Resident #65's "Fall Care Plan" revealed, "Resident flails/thrashes arms when providing care and at times when awake by self." During a telephone interview with Certified Nurse Aide (CNA) #5 on 3/25/26 at 2:57 PM, she revealed the day of Resident #65's fall she was providing care to the resident. She explained that he was clinching up, combative, and fighting back. CNA #5 stated she had raised his bed up and locked the bed and revealed she was holding onto him when he jerked and rolled off the bed and fell onto his buttocks. She stated staff were to check the care plan that was left in a binder at the desk to determine how much assistance a resident required. CNA #5 confirmed she had not checked his care plan to determine how much assistance was needed and stated, "We've always used one." She acknowledged having two (2) staff with the resident would have been appropriate due to his combative behaviors. During an interview with the Director of Nursing on 3/25/26 at 3:42 PM, she confirmed that after Resident #65's fall, there was not a review of the fall to determine the root cause, and no interventions were put into place to prevent a recurrence. She confirmed that if the resident fell out of bed while one aide was providing care, the number of staff assistance should have been increased to two (2). Record review of the "Demographics" revealed the facility admitted Resident #65 on 3/3/25 with a medical diagnosis that included Anoxic Brain Injury. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/25/26 revealed under section C, a Staff Assessment for Mental Status was completed and indicated Resident #65's cognitive skills for daily decision making was severely impaired.	M0640		
M0645	45.21.9 Nutrition	M0645		

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M0645	Continued from page 14 Nutrition. Residents shall maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless residents ' clinical condition indicates that this is unavoidable. All residents shall receive diets as orders by their physician or nurse practitioner/physician assistant. Residents identified with significant nutritional problems shall receive appropriate medical nutrition therapy based on current professional standards. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on record review, staff interview, and facility policy review, the facility failed to ensure adequate nutritional support and implementation of physician-ordered interventions to prevent significant weight loss for one (1) of six (6) residents reviewed for nutrition. Resident #1 Findings Include: Review of the facility policy titled “Weight Loss: Monitoring of” unrevised, revealed under, “Policy: It is the policy of ‘Proper name of the facility ‘that the weight and the nutritional status of residents be monitored.” Also revealed under, “Procedure: If a resident has a weight loss greater than 5 (five) percent of body weight in one month or 10 percent of body weight in a six month period, the dietician should be consulted, and recommendations of dietician should be followed.” Record review of Resident #1’s “Flowsheet History” revealed the following weights: Record review of Resident #1’s weights revealed on 9/17/2025, the resident weighed 135 pounds (lbs.). On 02/05/2026, the resident weighed 119 lbs., which was a significant weight loss of -11.85% (percent) in 6 months. On 12/11/2025, the resident weighed 132 lbs. On 2/05/2026, the resident weighed 119 lbs., which was a significant weight loss of -9.85% (Percent) in three (3) months. Record review of Resident #1’s meal intake “Flowsheet History” from 2/23/26 through 3/24/26 revealed a consistent pattern of poor oral intake, with the	M0645		

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M0645	Continued from page 15 resident consuming 25% (percent) or less of meals, including multiple documented entries of 0% intake, less than 25% intake, and refusals of meals. Further review revealed under, “Does the resident take their supplement?” No – activity did not occur was documented. Record review of Resident #1’s Registered Dietician (RD) “Progress Note” dated 2/24/26 revealed the residents documented PO (by mouth) intake average was 50-100 % (percent) for the majority of meals. On this day, the Registered Dietician (RD) spoke with the resident and documented his willingness to try chocolate Glucerna in the afternoon. An interview with the RD on 3/25/26 at 8:56 AM revealed Resident #1 was on a pureed diet in February and was receiving Glucerna three times daily with meals. She revealed the resident did not like the pureed diet or the Glucerna. The RD stated the resident's intake was averaging between 50-100% of meals, and on 2/24 he requested to change the Glucerna to once daily in the evening. She stated the recommendation was made on that day to change Glucerna to once daily. She revealed that she goes into the flowsheets to check and see if the resident was drinking it, but a lot of the time it was not documented, so she must go ask the nurse. After reviewing Resident #1’s supplement flowsheet, she confirmed there was no documentation to show the resident was receiving a supplement. After reviewing the physician orders with RD, the Glucerna order was entered into the system for only three (3) days and then stopped. She confirmed the resident did not get the recommended nutrients and protein that was ordered, which placed him at further risk for weight loss and malnutrition. Record review of Resident #1’s “Flowsheet History” revealed a monthly weight was obtained on 3/24/26 and was 115 lbs., which was down four (4) pounds from the last monthly weight in February, which was documented at 119. Record review of the “Canceled Orders” for Resident #1 revealed an order dated 2/24/26, “Glucerna; Chocolate chilled daily at risk for malnutrition, PO (by mouth) intake < (less than) 50% (percent) daily” with a duration of 3 days, confirming the resident was not receiving. Record review of the “Demographics” revealed the facility admitted Resident #1 on 4/28/25 with medical	M0645		

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M0645	Continued from page 16 diagnoses that included Acute Stroke due to Ischemia, at risk for Malnutrition, Dysphagia due to recent Stroke, and Vascular Dementia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/28/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 6, indicating Resident #1 was severely cognitively impaired.	M0645		
M0715	45.24.4 Labeling of drugs Labeling of drugs. Each facility shall follow the Mississippi State Board of Pharmacy labeling requirements. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, staff interview, and facility policy review, the facility failed to ensure medications and treatment solutions were secured and not accessible to the resident for three (3) of four (4) survey days. Findings Include: Review of the facility policy titled “Medication Administration” revised 3/11/24 revealed, “3. No medications should be left in the resident’s room.... 4. Storage of medications and several other associated products should be secure, i.e., in a locked drawer/cabinet, or under constant surveillance.” An observation inside room C3 on 3/23/26 at 11:12 AM and again on 3/24/26 at 8:14 AM revealed four (4) bottles of Dakin’s solution quarter-strength (1/4), 16 fluid ounce bottles; two (2) bottles sitting on a table beside the bed and the other two (2) in a pink pail over by the sink. Other items stored on the counter by the sink included a bottle of ethyl alcohol, 16-ounce bottle 70% (percent), and hydrogen peroxide 3% (percent). During an observation and interview with Licensed Practical Nurse (LPN) #1 on 3/24/26 at 2:42 PM, she confirmed treatment solutions were left in the room and were readily accessible. She stated these items should not be stored in the room due to the safety risk of a confused resident ingesting or misusing them.	M0715		

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M0715	Continued from page 17 On 3/25/26 at 10:42 AM, during an interview with the Director of Nursing, she confirmed treatment solutions should not be left at the bedside due to resident safety risk.Observation and interview on 3/26/2026 at 8:09 AM, while walking down the hallway, observed medication cart for Halls E and F unlocked and unattended. Registered Nurse (RN) #4 confirmed that the medication cart was unlocked and unattended. The assigned cart nurse, Licensed Practical Nurse (LPN) #2, returned to the medication cart and acknowledged that she had walked away, leaving the cart unlocked. LPN #2 verbalized awareness of the risks associated with leaving the cart unsecured, stating, “Anyone could come to the cart and have access to anything in the cart.” LPN #2 further stated, “I just walked away for a minute, but I should not have left it unlocked.” On 03/26/2026 at 8:57 AM, an interview was conducted with the Director of Nursing (DON). The DON stated her expectation is that all medication carts remain locked at all times unless the nurse is actively obtaining medications. She further stated that an unlocked and unattended medication cart could lead to medication diversion by staff, residents, visitors, or others.	M0715		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard	M1570		

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M1570	Continued from page 18 precautions. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, staff interview, and facility policy review, the facility failed to maintain effective infection control practices as evidenced by uncovered clean utility cart, staff not wearing gowns for enhanced barrier precautions, and handling soiled linens without a barrier bag, increasing the risk of cross-contamination and infection transmission for one (1) of four (4) survey days. Findings Include: Review of the facility's policy titled, "EVS-Residential Laundry" with an issued date of 4/1/18, revealed under "Policy: All potentially contaminated linen should be handled with appropriate measures to prevent cross-transmission … Linen should be carried away from the body and clothing. …Clean linens and residential laundry should be stored on clean, covered carts. …" Review of the facility's policy titled, "Enhanced Barriers in Nursing Homes" with an approved date of 4/5/24, revealed under "Policy: It is the policy of "Proper Name" long term care facilities that appropriate infection control precautions be observed by personnel caring for residents in needed precautions." Under procedure: "Enhanced Barrier Precautions (EBP) is a strategy in nursing homes to decrease the transmission of certain MDRO's (multidrug-resistant organisms) when contact precautions do not apply. EBP refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities" On 3/25/26 at 10:15 AM, a clean utility cart on A Hall, between rooms A9-A11, was observed uncovered with clean supplies exposed. Resident gowns on the bottom shelf with the tie strings and gowns touching the floor. During an observation and interview on 3/25/26 at 10:30 AM, Certified Nurse Aide (CNA) #3 confirmed that the clean utility cart was uncovered, exposing the clean utilities on the cart. She further confirmed that the resident gowns on the bottom shelf with the fabric ties touching the floor were now dirty. CNA #3 confirmed the cart should always be covered and that the residents'	M1570		

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M1570	Continued from page 19 gowns touching the floor were unsanitary and could contribute to infection transmission. Further observation outside Room 9A on 3/25/26 at 10:32 AM revealed Enhanced Barrier Precautions (EBP) and Contact Isolation signage on the door. CNA #3 and Nurse Aide in training (NA) #4 entered room 9A and did not don personal protective equipment (PPE), which included a gown. When CNA #3 opened the door to exit the room, it was observed that the NA #4 was holding soiled linen against her body that was not contained in a barrier bag and neither CNA #3 nor the NA #4 had on a gown. CNA #3 confirmed that both residents in the room were under precautions and confirmed that they both had provided care for the resident in B bed, which was under enhanced barrier precautions, and they did not wear a gown. She confirmed that there was contact-isolation signage on the door for the resident in bed A. She confirmed that without wearing the appropriate PPE and taking precautions, they could spread infection. During an interview on 3/25/26 at 10:55 AM, the Infection Preventionist confirmed that clean linen carts must always be kept covered to reduce the risk of cross-contamination. She revealed that when a resident is on Enhanced Barrier Precautions (EBP) or any type of isolation, staff are required to wear the appropriate PPE, which always includes a gown. She further confirmed that when aides provided care to the resident in the B bed in Room 9A they should have worn a gown and should not have carried soiled linen against their body into the hallway without containing it in a blue barrier bag for proper placement in a soiled linen container. In an interview on 3/25/26 at 3:00 PM, the Director of Nurses (DON) revealed that staff should wear the appropriate PPE when providing care to residents under enhanced barrier or contact precautions. She confirmed by not adhering to these practices it increases the risk of infection transmission among residents and staff.	M1570		