STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255161	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nmmc Baldwyn Nursing Facility	739 4th Street South Baldwyn, MS 38824

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, and facility policy review, the facility failed to provide sufficient nursing staff to ensure residents received necessary care as evidenced by failure to complete activities of daily living (ADL) care, including bathing, grooming, and nail care; failure to ensure call lights were answered in a timely manner; and failure to address repeated concerns voiced by residents during resident council meetings regarding delays in care and unmet needs for three (3) of four (4) survey days. Findings include: Review of the facility's policy titled, Scheduling of Nursing Staff with a revision date of 03/20, revealed under Policy: It is the policy of (Proper Name) to provide consistent expectations and standardized scheduling processes in staff schedules enabling appropriate staffing levels to ensure patient and staff safety. An 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 1/2) 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. An observation and interview on 3/24/26 at 10:00 AM, Resident #54 stated, I was supposed to get a bath last night, but the two Certified Nursing Assistants (CNAs) were so busy, and I guess they couldn't get to me. At that time, 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, with a noticeable body odor. 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 stated, It looks like it's been a while since he was cleaned up to which Resident #54 stated, It's been two weeks. 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. An observation and interview on 3/24/2026 at 11:25 AM, the Director of Nurses (DON) confirmed that Resident #54 and Resident #10 were not adequately groomed and acknowledged that it appeared they 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 residents' ADL needs. During an interview on 3/25/26 at 8:25 AM, the DON revealed the facility primarily utilizes agency staff and confirmed there are frequent (continued on next page)

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	call-ins that they aren't able to replace. Although efforts are made to cover each shift, the facility may still operate short-staffed at times. The DON acknowledged that maintaining adequate staffing has been an ongoing struggle. An observation and interview on 3/25/26 at 10:12 AM, revealed a call light illuminated in the hallway for room A9. Upon entering the room, Resident #54 stated, I need to be changed. I turned my light on a while ago, and I'm just waiting. Further observation from the hallway revealed no staff present in the immediate area. Upon approaching the nurses' station at the end of the hallway, it was noted that the call light alarm was not sounding. The Unit Coordinator stated, I'm aware of his call light, and I've already paged overhead for his CNA, and it is silenced now. An observation of Registered Nurse (RN) #2 and the Unit Coordinator at the nurses' station. During continued observation from the hallway, the unit manager paged the assigned CNA twice more for room [ROOM NUMBER]. An observation and interview on 3/25/26 at 10:30 AM, Certified Nurse Aide (CNA) #3 and Nurse Aide in training (NA) #4 returned to the hall. CNA #3 stated, We finished our rounds earlier, and we went on our 15-minute break, and further indicated that another staff member should have responded to the call light in her absence. During the Resident Council meeting held on 3/25/26 at 2:00 PM, residents expressed that staffing was their primary concern. One resident reported that she had previously been told that she would have to wait until the following day to have certain care needs addressed. Although she was initially unable to specify the type of care referenced, when prompted about showers, she confirmed that this included bathing. Another resident further stated that she had experienced extended wait times for toileting assistance on approximately three (3) occasions, occurring at random times without a specific shift identified. During a phone interview on 3/25/26 at 2:05 PM, an anonymous nursing staff member reported that the facility is, at times, staffed with only four (4) to five (5) CNA's for the entire facility. An interview on 3/26/26 at 7:55 AM, CNA #6, revealed that staffing issues are frequent, with shifts often short due to call-ins. CNA #6 reported that staff turnover has occurred, stating some staff have left due to routinely working short-staffed. She confirmed that when staffing is insufficient, residents may miss scheduled baths as staff prioritize completing essential tasks. CNA #6 stated, The DON is aware of these concerns and attempts to provide incentives, but confirmed staffing challenges persist. During an interview on 3/26/26 at 8:05 AM, the Unit Coordinator revealed she holds multiple roles within the facility. She stated that today she was working in restorative care, and on the previous day she had served as the Unit Coordinator. She further revealed that she is also a CNA. In an interview on 3/26/26 at 8:45 AM, the DON confirmed that when a CNA is on break, another aide is expected to provide coverage; however, if staff are occupied, any available nursing staff are expected to respond to call lights and assist residents. The DON acknowledged the facility has experienced ongoing difficulty ensuring sufficient staffing to meet resident needs.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] with diagnoses including Heart Failure, Dementia, Mood Disorder, Anxiety and Depression.Record review of the MDS with an Assessment Reference Date (ARD) of 3/04/2026 revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident had moderate cognitive impairment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interviews, record reviews, and facility policy reviews, the facility failed to implement a Catheter and Activities of Daily Living (ADL) care plan for five (5) of 25 resident care plans reviewed. (Resident #4, Resident #7, Resident #10, Resident #46, and Resident #54) Findings include: Record review of facility policy titled, Care Plan Policy with most recent revision date of 10/24, revealed, .In accordance with each resident's plan of care, all services provided or arranged by the facility should meet professional standards of quality and should be provided by qualified persons Resident #4 Record review of the Care Plan revealed, Requires a foley catheter related to neurogenic bladder.Approaches.Secure catheter to prevent trauma. On 3/24/26 at 2:10 PM during an interview and observation of catheter care by Certified Nursing Assistant (CNA) #2, 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. On 3/24/26 at 2:20 PM an interview 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 which was a part of the care plan for catheter care. During an interview on 3/24/26 at 3:20 PM, the Minimum Data Set (MDS) Coordinator acknowledged that each resident with an indwelling catheter should have a bowel and bladder care plan which included care for the catheter. She confirmed the facility failed to implement the care plan for catheter care which included usage of a securing device. Record review of Demographics page for Resident #4 revealed resident was admitted to the facility on [DATE]. 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 9 which indicated a moderate cognitive impairment. Resident #7 Record review of Resident #7's care plan revealed the resident required assistance with activities of daily living, including personal hygiene and grooming needs such as nail care and shaving. On 3/23/26 at 11:40 AM during an observation with Resident #7 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 chin hair approximately (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	one-fourth (1/4) inch in length. During an observation on 3/26/26 at 8:50 AM, the DON observed 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. During an interview on 3/26/26 at 9:00 AM, the MDS Coordinator stated that the care plan provides guidance for each resident's care needs. She confirmed that Resident #7's care plan included activities of daily living interventions such as grooming and hygiene; however, the care plan was not implemented for this resident. Record review of Resident #7's admission Record revealed the resident was admitted to the facility on [DATE]. Record review of Resident #7's Medical Problems list revealed diagnoses including functional quadriplegia, muscle spasticity, and ataxia. Record review of the MDS with an ARD of 12/24/2025 revealed a BIMS score of 13, indicating the resident was cognitively intact. Resident #10 Record review of Resident #10's care plan revealed the resident required assistance with activities of daily living, related to a diagnosis of Cerebral Vascular Disease (CVA) and left side hemiplegia. Personal hygiene and grooming include bathing, nail care, and shaving. An 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 1/2) 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. On 3/24/26 at 11:20 AM during an observation and interview, the DON confirmed Resident #10 was not adequately groomed. and further acknowledged the resident's personal hygiene plan of care was not followed. During an interview on 3/24/26 at 2:30 PM, the MDS Coordinator stated the purpose of the care plan is to guide staff in providing individualized care to each resident. She confirmed the ADL care plan for Resident #10 was not being implemented with regard to his personal hygiene and acknowledged it should have been followed. Record review of the Demographics page revealed Resident #10 was admitted to the facility on [DATE]. 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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 Record review of Resident #46's Care Plan revealed, Resident requires assist with ADL's related to CVA and weakness. On 3/23/26 at 4:30 PM during an observation and interview with Resident #46, 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. During an observation on 3/24/26 at 8:30 AM, the DON observed 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 met. She confirmed that shaving was part of the ADL care plan and for this resident, the care plan was not implemented. During an interview on 3/24/26 at 2:30 PM, the MDS Coordinator revealed the care plan provided a guide for the care needs of each resident. She stated this resident had an activity of daily living care plan which would include shaving, but this was not implemented for the resident. Record review of the Demographics page revealed the resident was admitted to the facility on [DATE]. 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 Record review of Resident #54's care plan revealed the resident required assistance with activities of daily living, related to weakness, history of Traumatic Brain Injury (TBI) and Chronic pain. Personal hygiene and grooming include bathing, nail care, and shaving. On 3/23/26 at 10:50 AM during an observation and interview, 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. On 3/24/2026 at 11:25 AM during an observation and interview, 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 and the resident's plan (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of care was not being followed regarding his personal hygiene. During an interview on 3/24/26 at 2:30 PM, the MDS Coordinator stated the purpose of the care plan is to guide staff in providing individualized care to each resident. She confirmed that the Activities of Daily Living (ADL) care plan for Resident #54 was not being implemented regarding his personal hygiene and acknowledged that it should have been followed. Record review of the Demographics page revealed Resident #54 was admitted to the facility on [DATE]. 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. 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.

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	255161	A. Building B. Wing	03/26/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. 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 [DATE]. 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 1/2) 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 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	done. I really need them cut. 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 [DATE]. 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 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 [DATE]. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, 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 [DATE]. 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. 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255161	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nmmc Baldwyn Nursing Facility	739 4th Street South Baldwyn, MS 38824

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. 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 [DATE]. 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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 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: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. An observation outside Resident #65's room on 3/23/26 at 12:20 PM revealed that 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.An interview with Licensed Practical Nurse (LPN) #1 on 3/24/26 at 2:41 PM 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 bilateral arms and legs were contracted and he 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 activities of daily living (ADL) Task revealed the resident was total dependence for bed mobility and total dependence with toileting assistance without reference to a number of staff required. An interview with the Registered Nurse (RN) #3 on 3/25/26 at 1:36 PM confirmed that Resident #65's 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. A telephone interview with Certified Nurse Aide (CNA) #5 on 3/25/26 at 2:57 PM 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. An interview with the Director of Nursing (DON) on 3/25/26 at 3:42 PM 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 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255161	A. Building B. Wing	03/26/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Mental Status was completed and indicated Resident #65's cognitive skills for daily decision making were severely impaired.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE]. 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.

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	255161	A. Building B. Wing	03/26/2026

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 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 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 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.

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	255161	A. Building B. Wing	03/26/2026

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, record review, staff interview, and facility policy review, the facility failed to ensure the safe use, assessment, and ongoing evaluation of bed rails and failed to identify and remove a known entrapment hazard for one (1) of 25 sampled residents. Resident #65 Findings Include: Record review of the facility policy titled Bed Rails revised 9/18, revealed under, Policy: It is the policy of ?Proper name of the facility' that bed rails should be used appropriately. This failed practice was not in accordance with facility policy requiring appropriate use and assessment of bed rails. An observation of Resident #65 on 3/23/26 at 12:20 PM revealed he was lying in bed, awake and non-verbal. The left side of the bed was against the wall and one-half (1/2) upper side rails were observed to the left and right side of the bed with a fall mat on the floor. Record review of Resident #65's Significant Event Note dated 3/3/26 revealed, I heard residents peg (percutaneous endoscopic gastrostomy) pump going off, upon entering room Director of Nursing (DON) was standing next to resident, he was halfway on the bed. Legs and arms were in the floor on the protective mat. Resident was flipped face over into the mattress against the rail, his nose and mouth were not into the mattress but in between mattress and rail. Further review revealed the bed was against the wall to prevent falls with no indication the side rails were identified as a source for entrapment. Record review of Resident #65's Fall Care Plan revealed the resident flails/thrashes arms when providing care and at times when awake by self. An interview with Licensed Practical Nurse (LPN) #1 on 3/24/26 at 2:41 PM revealed the resident was a high risk for falls. She revealed the resident was contracted and he rocked his body side to side in the bed when he was wet or in pain which increased his safety risk. She revealed the resident could not use his side rails for bed mobility and confirmed he was totally dependent for care and could not reach out or grab the rails with turning and repositioning. Record review of Resident #65's Side Rail Evaluation dated 3/3/25 revealed the resident was currently using the side rails for positioning or support, did not have a history of falls, and expressed a desire to have the side rails raised while in bed. The side rail assessment was not updated when the resident fell on 3/3/26 despite a significant change in condition. Record review of Resident #65's Bed Rail Consent revealed the Responsible Party (RP) agreed to use bed rails on admit 3/3/25. An interview with the DON on 3/24/26 at 3:12 PM revealed the day of Resident #65's fall she responded to the room because she heard his feeding pump alarming. She observed the resident with his legs and arms on the protective mat and his head was face down in between the side rail and mattress. The DON confirmed the resident was at a greater risk of side rail entrapment and suffocation than from falls and acknowledged the bed rails should have been immediately removed. An interview with the Minimum Data Set (MDS) Nurse on 3/25/26 at 11:10 AM revealed MDS was responsible for updating the side rail assessment quarterly and confirmed this was not being done. She confirmed after reviewing the last fall note the resident was at risk for entrapment from his side rails and they should have been removed. 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 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 were severely impaired, which increased his inability to protect himself from harm.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [ROOM NUMBER]. 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 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). An observation and interview with Licensed Practical Nurse (LPN) #1 on 3/24/26 at 2:42 PM 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. An interview with the Director of Nursing on 3/25/26 at 10:42 AM 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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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' gowns touching the floor were unsanitary and could contribute to infection transmission. Further observation outside room [ROOM NUMBER]A 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 [ROOM NUMBER]A 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 [ROOM NUMBER]A 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.