

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30PL	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER PLAZA COMMUNITY LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4403 HOSPITAL ROAD PASCAGOULA, MS 39581		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey with Complaint Investigations (CIs), MS #26993, CI MS #26961, and CI MS #26842, at the facility from 1/06/25 through 1/09/25. The SA investigated CI MS #26993 for abuse and neglect and CI MS #26842 for quality of care and dignity and there were no citations related to those CIs. The SA investigated CI MS #26961 related to resident on resident abuse, dignity, safety and infection control and cited M500 and M640. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M500, M640, M815, M1210, and M1570.	M 000		
M 500	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;	M 500		2/13/25

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/02/25

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M 500	Continued From page 1 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 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,	M 500		

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M 500	Continued From page 2 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 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;	M 500		

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M 500	Continued From page 3 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 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 Statute is not met as evidenced by:	M 500		

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M 500	Continued From page 4 Level II Based on observation, interview, record review, and facility policy review, the facility failed to protect residents' right to be free from physical abuse when Resident #62 received scratches to his neck and face in an altercation with Resident #48 and Resident #41 received a hematoma to her head during an altercation with Resident #78 for four (4) of 20 sampled residents. Findings included: A review of the facility's "Abuse, Neglect, Exploitation, and Misappropriation Prevention Program," updated October 2022, revealed, "Residents have the right to be free from abuse, neglect, misappropriation of property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms." Resident #48 and Resident #62 Altercation Record review of the facility's investigation dated 11/2/24 revealed Resident #62 and Resident #48 were involved in an altercation in the dining room. Resident #62, who was assisting with handing out clothing protectors, was punched by Resident #48 when he attempted to place a clothing protector on him. In response, Resident #62 hit Resident #48 back, and both residents fell to the floor. A dietary aide witnessed the incident, reported it to Registered Nurse (RN) #4 and both residents were separated. Resident #62 sustained scratches to his face and neck, while Resident #48 had no noted injuries. The physician, Director of Nursing (DON), and Administrator were	M 500	The facility failed to protect residents' right to be free from physical abuse for resident # 62, #48, #78 and #41. Residents #62 and #48 were interviewed by the Social Service Director concerning the incident that occurred on 11/2/24 on 01/10/25. No adverse effects were noted. There have been no further issues between resident # 62 and #48 since 11/2/24. Residents #78 and #41 were interviewed by the Social Service Director concerning the incident on 01/07/25. Both residents have no adverse effects. All residents have the potential to be affected. All staff were educated beginning 01/10/25 and ending 01/31/2025 on abuse, neglect and exploitation policy the Director of Nursing and Nursing Administration staff. The Social Service Director conducted a person-centered in-service on resident #62 for all staff. All staff were educated on residents' rights on 01/10/25 and ending 01/31/2025. On 01/07/2025, the dining area which leads to the smoking area was opened to residents to wait for smoke break so they can spread out more. On 01/07/2025, staff were informed that residents, when grouping together before smoke break or during mealtimes, must be supervised in the main dining room. The dining room will only be open for activities, mealtimes and when waiting to smoke. The administrator met with the smokers on 01/13/25 and explained that the area to wait for smoke break will not be opened until 20 minutes prior to scheduled smoke time. Residents were	

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M 500	Continued From page 5 notified. Interventions included instructing staff to prevent Resident #62 from distributing clothing protectors in the dining room and referring Resident #48 to the in-house psychiatric Nurse Practitioner. During an observation on 1/6/2025 at 10:50 AM, Resident #48 was noted sitting in his wheelchair in his room. Resident #48, who has expressive aphasia, communicated with head nods. During an interview on 01/06/2025 at 11:00 AM, Registered Nurse (RN) #3 explained that Resident #48 can talk but may not want to communicate because he cannot speak clearly. RN #3 reported she did not recall many details about the night Resident #48 and Resident #62 were involved in an altercation in the dining room. She noted both residents have a history of other altercations, which usually occurred due to Resident #62 wandering into rooms. RN #3 added that Resident #48 had hit Resident #62 previously when Resident #62 wandered into his room. During an observation and interview on 01/08/2025 at 09:30 AM, Resident #48 was observed sitting in his wheelchair in his room. When asked if he could answer yes or no questions, the resident nodded yes. When asked if he remembered the altercation in the dining room with Resident #62, the resident nodded yes. When asked if he and Resident #62 had previous issues, he nodded yes. When asked if he was upset about the clothing protector, he nodded no. When asked if he became upset when he saw it was Resident #62, he nodded yes. When asked if he landed on the floor during the incident, he nodded yes. When asked if he was hurt, he nodded no. When asked if he had punched	M 500	asked to please not come down an hour before smoke breaks. Resident #62 will be monitored to ensure he does not hand out clothing protectors starting 01/10/25 and ending 03/01/2025. The Quality Assurance Performance Improvement (QAPI) Team met on 01/10/25 and discussed policies and procedures on abuse, neglect, and exploitation with no revisions needed at this time. All residents will be supervised while in the main dining area while gathering for smoke breaks, mealtimes, and activities. The Life Connections Department will use a daily monitoring tool beginning 01/13/25 ending 03/01/25 to ensure the main dining area is being supervised during smoke breaks, mealtimes, and activities. Any adverse findings will be reported to the Administrator or Director of Nursing. All findings will be reported to the QAPI Team monthly beginning 02/13/25 and ending 03/31/25 for review and recommendations.	

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M 500	Continued From page 6 Resident #62 before, he nodded yes. When asked if this occurred when Resident #62 came into his room, he nodded yes. When asked if he had any further altercations with Resident #62 since the dining room incident, he nodded no. When asked if everything was better now, he nodded yes and smiled. During an interview on 01/08/2025 at 12:15 PM, Dietary Aide #4 confirmed she provided a witness statement for the incident between Resident #48 and Resident #62. She stated the incident occurred around 5:20 PM as the dining room trays are typically distributed starting at 5:25 PM. She was at the kitchen window and saw Resident #62 walking around placing clothing protectors on other residents. Resident #48 was seated at the back table. When Resident #62 attempted to place a clothing protector on Resident #48, Resident #48 punched Resident #62, who punched him back, leading to a tussle. Dietary Aide #4 stated she told other kitchen staff the residents were fighting and then saw Resident #48 fall from his wheelchair to the floor. She immediately sought help from a nurse and Certified Nursing Assistant (CNA). She stated that residents were temporarily prohibited from being in the dining room without staff for about a week after the incident, but that policy was not maintained because residents would often gather unsupervised in the hallways instead. During a phone interview on 01/08/2025 at 05:40 PM, RN #5 stated she did not witness the incident between Resident #48 and Resident #62. She explained that Dietary Aide #4 informed her about the altercation. While walking down the hall, she encountered RN #4, who was with Resident #62. RN #4 informed her that Resident #62 had been fighting with another resident. RN #5 then	M 500		

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M 500	Continued From page 7 escorted Resident #62 to his room and completed a body audit. She observed scratches on Resident #62's neck and face, noting that the scratches were superficial and required only first aid. RN #5 stated she completed the incident report for Resident #62, while RN #3 completed the incident report for Resident #48. She also confirmed she notified the Administrator and Director of Nursing (DON) about the incident. During a interview on 01/09/2025 at 03:50 PM, the Administrator stated that on the night of the incident, she was notified, and the RNs completed the incident reports. She used the incident reports and statements from RN #4 and Dietary Aide #4 to complete her final report. She explained that she does not know if any other residents were present in the dining room at the time of the incident, except for Resident #26, whose interview was included in one of the incident reports. She acknowledged there were no staff in the dining room at the time of the altercation, as they were busy assisting other residents to the dining room. She confirmed interventions implemented included informing Resident #62 that he could no longer distribute clothing protectors and instructing staff not to allow him to pass out the clothing protectors. A record review of progress notes dated 6/3/2024 at 5:45 PM revealed that Resident #48 and Resident #62 had a prior altercation. The progress notes stated, "This writer was walking the hallway and noticed a wheelchair flipped up in the room. Upon entering the room, the resident was noted sitting in his wheelchair, and another male resident was on the floor underneath Resident #48's wheelchair. Both residents were exchanging punches and holding each other's shirts." When asked how the altercation occurred,	M 500		

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M 500	Continued From page 8 Resident #48 stated, "He came in my room, and I asked him to get out and he wouldn't and got smart with me." When asked, "Who struck who first?" Resident #48 admitted to striking the other resident first. Both residents were separated by this writer and two other staff members and assessed for injuries. Upon assessment, Resident #48 was noted to have two small scratches on his left cheek. The areas were cleaned and left open to air. The family, physician, Director of Nursing (DON), and Administrator were notified of the incident. A record review of the "Admission Record" revealed the facility admitted Resident #48 on 05/07/20 with the diagnoses including Hemiplegia And Hemiparesis Following Cerebral Infarction. A record review of the Quarterly MDS with an ARD of 10/09/24 revealed Resident #48 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. A record review of Resident's "Physical Aggression Initiated" report dated 11/02/24 prepared by RN #3 revealed " ... I did not witness event. I was told by resident 48 and resident #62, that Resident #62 put on the clothing protector. Resident #62 put it on Resident #48 took it off then resident #48 hit Resident #62 in the gut, Resident #62 returned hit to Resident #48 in the torso ... Nursing supervisor notified by RN #5. Residents were separated ... no injuries observed at time of incident ... No statements found ..." A record review of the "Admission Record" revealed the facility admitted Resident #62 on 01/26/22 with the diagnoses including Unspecified Dementia.	M 500		

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M 500	Continued From page 9 A record review of the Quarterly MDS with an ARD of 12/11/24 revealed Resident #62 had a BIMS score of 7 which indicated he was severely cognitively impaired. A record review of Resident's "Physical Aggression Initiated" report dated 11/02/24 prepared by RN #3 revealed " ... I did not witness event. I was told by resident #48 and Resident #26, that Resident #62 put bib on Resident #48 took it off then Resident #48 hit Resident #62 in the gut, Resident #62 returned hit to Resident #48 torso ... Nursing supervisor notified by RN #5, residents were separated ... no injuries observed at time of incident ... No statements found ..." Resident #41 and Resident #78 Altercation On 1/7/2025 at 5:15 PM, during an observation, several residents were standing in the hallway near the main dining room without staff supervision. Residents were overheard using profanity, and Resident #78 was observed hitting Resident #41 with her walker, knocking her to the floor. Staff intervened and separated the residents. A record review of the facility's incident reports dated 1/7/2025 revealed Resident #41 sustained a hematoma to the back of her head and was sent to the emergency room for evaluation. Resident #78 denied hitting Resident #41 with her walker and reported no injuries. A record review of the "Admission Record" revealed the facility admitted Resident #41 on 3/21/2023 with diagnoses including Chronic Obstructive Pulmonary Disease.	M 500		

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M 500	Continued From page 10 A record review of the Quarterly Minimum Data Set (MDS) with an assessment Reference Date (ARD) of 11/20/2024 revealed Resident #41 had a Brief Interview for Mental Status (BIMS) score of three (3), indicating severe cognitive impairment. A record review of the "Admission Record" revealed the facility admitted Resident #78 on 3/22/2023 with diagnoses including Dementia. A record review of the Quarterly MDS with an ARD of 10/24/2024 revealed Resident #78 had a BIMS score of seven (7), indicating severe cognitive impairment.	M 500		
M 640	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 Statute is not met as evidenced by: Level II Based on observation, interviews, record review, and the facility policy review the facility failed to provide adequate supervision to prevent resident-on-resident altercations between Resident #62 and Resident #48 and between Resident #41 and Resident #78 for four (4) of 22 sampled residents. Findings included:	M 640	The facility failed to protect residents #62, #48, #78 and #41 from accidents and hazards. Residents #62 and #48 were interviewed by the Social Service Director concerning the incident that occurred on 11/2/24 on 01/10/25. No adverse effects were noted. There have been no further issues between resident # 62 and #48 since 11/2/24. All residents have the potential to be	2/13/25

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M 640	Continued From page 11 Resident #48 and Resident #62 Record review of the facility's investigation dated 11/2/24 revealed Resident #62 and Resident #48 were involved in an altercation in the dining room. Resident #62, who was assisting with handing out clothing protectors, was punched by Resident #48 when he attempted to place a clothing protector on him. In response, Resident #62 hit Resident #48 back, and both residents fell to the floor. A dietary aide witnessed the incident, reported it to Registered Nurse (RN) #4 and both residents were separated. Resident #62 sustained scratches to his face and neck, while Resident #48 had no noted injuries. The physician, Director of Nursing (DON), and Administrator were notified. Interventions included instructing staff to prevent Resident #62 from distributing clothing protectors in the dining room and referring Resident #48 to the in-house psychiatric Nurse Practitioner. On 01/06/2025 at 11:51 AM, during an observation in the dining room, Resident #26 was placing clothing protectors on other residents without staff present. On 01/07/2025 at 02:20 PM, during an interview, Resident #26 confirmed he witnessed the altercation between Residents #62 and #48. He stated that no staff were present in the dining room at the time and that it was common for the dining room to be unsupervised. On 01/08/2025 at 12:15 PM, during an interview, Dietary Aide #4 stated she observed the altercation between Residents #62 and #48 on 11/2/24 from the kitchen window and sought help from a nurse and Certified Nursing Assistant	M 640	affected. All staff were educated beginning 01/10/25 and ending 0/31/2025 on abuse, neglect and exploitation and accidents and incidents-investigating and reporting policies the Director of Nursing and Nursing Administration staff. The Social Service Director conducted a person-centered in-service on resident # 62 for all staff. The dining area which leads to the smoking area was opened to residents to wait for smoke break so they can spread out more. Staff were informed that residents, when grouping together before smoke break or during mealtimes, must be supervised in the main dining room. On 01/10/25, the dining room will only be open for activities, mealtimes and when waiting to smoke. The administrator met with the smokers on 01/13/25 and explained that the area to wait for smoke break will not be opened until 20 minutes prior to scheduled smoke time. Residents were asked to please not come down an hour before smoke breaks. Residents #78 and #41 were interviewed by the Social Service Director concerning the incident on 01/07/25. Both residents have no adverse effects. The administrator met with Resident Council on 01/28/25 concerning supervision in the main dining area for mealtimes, activities, and waiting for smoke break. Residents were told the main dining room will be closed except for mealtimes, activities, and 20 minutes prior to smoke break. The Quality Assurance Performance Improvement (QAPI) team met on	

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30PL	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER PLAZA COMMUNITY LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4403 HOSPITAL ROAD PASCAGOULA, MS 39581		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 640	Continued From page 12 (CNA). She confirmed there were no staff in the dining room at the time. Dietary Aide #4 added that after the incident, residents were temporarily prohibited from being in the dining room without staff, but this restriction was not maintained. A record review of the "Admission Record" revealed Resident #62 was admitted by the facility on 01/26/2022 with diagnoses including Unspecified Dementia and Psychotic Disorder. A record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/11/2024 revealed Resident #62 had a Brief Interview for Mental Status (BIMS) score of seven (7), indicating severe cognitive impairment. A record review of the "Admission Record" revealed Resident #48 was admitted by the facility on 05/07/2020 with diagnoses including Hemiplegia and Aphasia. A record review of the MDS with an ARD of 10/09/2024 revealed a BIMS score of 15, indicating the resident was cognitively intact. Resident #41 and Resident #78 On 01/07/2025 at 03:00 PM, during an observation there was an altercation between Resident #78 and Resident #41 near the exit door for smoking, which is near the dining room. No staff were present at the time of the incident. Record review of the facility's, "Incident Report", dated 01/07/25 revealed Resident #41 was walking in the hallway next to the kitchen when another resident called this resident a (expletive) this resident then called the other resident a (expletive) and then proceeded to slap the other	M 640	01/10/25 and discussed policies and procedures on abuse, neglect and exploitation and accidents and incidents ☐ investigating and reporting with no revisions needed at this time. All incidents and accidents will be monitored 5 times a week in our morning clinical meetings starting 01/13/2025 and ending 02/28/25 to ensure proper investigating and reporting and to ensure interventions are in place. All findings will be reported to the QAPI team of all accidents and incidents starting 02/13/25 and ending 03/31/2025.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30PL	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/09/2025
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M 640	Continued From page 13 resident in the face. Both residents began pushing each other when the Resident #78 pushed Resident #41 with her wheelchair, knocking Resident #41 to the floor where she hit the back of her head. The staff immediately intervened and assessed the resident for injury. Resident #41 noted to have quarter sized hematoma to the back of her head. Charge nurse took Resident #41's vital signs, and the Medical Director and family was notified the resident was sent to the local emergency room for an evaluation. A record review of Resident #41's "Admission Record" revealed the resident was admitted on 03/21/2023 with diagnoses including Chronic Obstructive Pulmonary Disease and Major Depressive Disorder. A record review of Resident #41's MDS dated 11/20/2024 revealed a BIMS score of (3), indicating severe cognitive impairment. A record review of Resident #78's "Admission Record" revealed the resident was admitted on 03/22/2023 with a diagnosis of Unspecified Dementia. A record review of Resident #78's MDS dated 10/20/2024 revealed a BIMS score of seven (7), indicating severe cognitive impairment.	M 640		