STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255192	A. BUILDING _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE COUNTY SENIOR CARE	2124 OLD HWY 61 SOUTH PORT GIBSON, MS 39150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and Complaint Investigation (CIs), MS #29311 at the facility from 6/16/25 through 6/19/25. The SA investigated CI MS #29311 for quality of care related to treatment, environment and medications not given according to physician orders and F690 was cited related to CI MS# 29311. During the annual recertification survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F605, F690, F812 and F880. The facility had a census of 66 and was licensed for 75 beds.	F 000		
F 605 SS=E	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2), 483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any	F 605		7/27/25

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

Electronically Signed | 07/09/2025

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F 605	Continued From page 1	F 605		

physical or chemical restraint not required to treat the resident's medical symptoms.
§483.12(a) The facility must-. . .
§483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms.
. . . .
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic.

§483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-
(1) In excessive dose (including duplicate drug therapy); or
(2) For excessive duration; or
(3) Without adequate monitoring; or
(4) Without adequate indications for its use; or
(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.

§483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--

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F 605	Continued From page 2 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, and facility policy review the facility failed to discontinue an as-needed (PRN) order for a psychotropic medication beyond the allowable	F 605	The medication regimen for resident #58 was reviewed by the physician on 6//19/25. The antipsychotic medication that was prescribed for as needed (PRN)	

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F 605	Continued From page 3 fourteen (14) day period, for one (1) of five (5) medication reviews (Resident #58). Findings included: A review of the facility's policy, "Medication Monitoring (Drug Regimen Review Monthly Review)," undated, revealed, "The facility supports pharmacy services that promote quality care including drug regimen review (DRR). DRR is defined as the systematic evaluation of drug therapy viewed within the context of resident-specific data. The consultant pharmacist reviews the medication regimen of each resident at least monthly. Findings and recommendations are reported to the Administrator, Director of Nursing, the attending physician, and the Medical Director, when appropriate." A record review of Resident #58's Physician Orders revealed an order dated 5/24/2024 for Haldol Decanoate Intramuscular Solution 50 MG/ML (milligrams/milliliters) to inject fifty (50) mg intramuscularly as needed for increased agitation and aggressive behavior, not to exceed 100 mg per month, and an order dated 9/11/24 for Haldol Decanoate Intramuscular Solution 50 MG/ML (Haloperidol Decanoate) to be administered once a month on the twenty-third (23rd) of each month. A record review of Resident #58's Electronic Medication Administration Record (eMAR) for May and June 2025 revealed the resident did not receive the PRN dose of Haldol. On 06/19/2025 at 11:42 AM, during a phone interview with the Nurse Practitioner (NP), they explained that they review all medications and	F 605	use for aggressive behavior had not been used and discontinued. A review of all PRN psychotropic medications, stop dates and indications for use was completed on 6/23/25 by the Director of Nursing (DON). All residents that use PRN psychotropic medications have the potential to be affected. All licensed nurses were in-serviced regarding facility policy for use of psychotropic medications by the DON on 6/20/25. A copy of the regulations regarding unnecessary medication were provided to physician as a resource by the DON on 6/23/25. The DON and medical records nurse will complete audits of three (3) records times six (6) weeks then monthly on ongoing basis with chart check audits beginning 6/23/25. Audit will ensure that appropriate indications for use of psychotropic medications are clearly documented with correct sequence of ordering (PRN for the 14 days and then reevaluate if needed). The DON will bring audit results to the Quality Assurance (QA) committee meetings beginning 7/25/25 monthly for three (3) months and any revisions made as necessarry.	

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F 605	Continued From page 4 orders. They reported the Haldol order should be discontinued after fourteen (14) days and that Haldol cannot be written as an as-needed medication for a year. On 06/19/2025 at 1:19 PM, during a phone interview with the Pharmacy Consultant, she explained that she visits the facility monthly and review orders. She stated that when an order needs to be stopped after fourteen (14) days, a note is placed in the dashboard. She stated that to continue Haldol beyond fourteen (14) days, a physician must conduct a physical evaluation and rewrite the order. On 06/19/2025 at 2:08 PM, during an interview with the Director of Nursing (DON), she explained the order should have been discontinued after fourteen (14) days. She stated that to maintain the order, a new evaluation and written order are required. She acknowledged that it is their responsibility along with the Charge Nurse to ensure this is completed and reported the oversight was due to human error. A record review of Resident #58's Admission Record revealed an admission date of 12/21/2023, with diagnoses including Schizophrenia, unspecified, and Major Depressive Disorder. A record review of Resident #58's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/17/2025 revealed a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicates cognitively intact.	F 605		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		7/27/25

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F 690	Continued From page 5 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, the facility failed to	F 690	Residents #9 and #15 are receiving proper incontinent care as required. The	

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F 690	Continued From page 6 provide peri-care in accordance with professional standards of care for two (2) of four (4) peri-care observations (Resident #9 and Resident #15). Findings included: A review of the facility's policy, "Perineal Care Policy," with a revision date of 1/2010, revealed, "POLICY It is the policy of this facility to provide perineal cleanliness and comfort to the resident, to prevent infection and skin irritation and to observe the resident skin condition..." Resident #9 On 06/17/2025 at 2:10 PM, during an observation of peri-care for Resident #9 provided by Certified Nursing Assistant (CNA) 1 and assisted by CNA #2 revealed CNA #1 placed items on the nightstand beside the bed without a barrier in place. CNA #1 pulled out four wipes and cleaned the vaginal area front to back, pulling wipes from the pack a total of four times with soiled gloves. Resident #9 had feces in the back of her brief. CNA #1 removed gloves, sanitized hands, and proceeded to perform care in the buttocks area, again pulling wipes from the pack four times after starting care with dirty gloves. They then removed gloves, applied hand sanitizer, put on clean gloves, and applied a clean brief. Upon request by the State Agency to check for cleanliness, CNA #1 removed the brief and wiped a total of six additional times, each with visible smears of feces, until the resident was clean. On 06/17/2025 at 2:23 PM, during an interview with CNA #2, she explained that Resident #9 had smears of feces during the recheck. They stated that inadequate peri-care can lead to skin	F 690	Director of Nursing (DON) assessed residents #9 and #15 on 6/19/25 with no skin breakdown or signs of infection noted. All residents who require incontinent care have been assessed by DON or Infection Prevention (IP) Nurse between 6/20/25 and 6/23/25 with skin breakdown or signs of infection noted. All residents who require incontinent care have the potential to be affected by this deficient practice. Certified Nurse Aides (CNA'S) #1, #2 #3 and #4 were in-serviced between 6/20/25 and 6/23/25 on their next scheduled workday in a one-on-one meeting with IP nurse and DON. Skills were demonstrated per the IP nurse and a return demonstration was provided by each CNA. All CNA's were in-serviced on incontinent care by the IP Nurse and DON between 6/20/25 and 6/24/25 with demonstrations, videos with return demonstrations performed by all participants. CNA's were able to verbalize the effects of performing incontinent care that was unsatisfactory such as skin breakdown, the risk of urinary tract infections and uncleanliness. The IP nurse, Staff development nurse and DON will monitor incontinent care on three (3) residents, three (3) times weekly times six (6) weeks then three (3) residents weekly times six (6) weeks beginning 6/20/25 to ensure incontinent care is performed properly. Findings of monitors will be brought to the Quality	

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F 690	Continued From page 7	F 690		

breakdown.

On 06/17/2025 at 2:31 PM, during an interview with CNA #1, she confirmed that smears of feces were present during the recheck. She acknowledged that improper care could result in infection and skin breakdown.

On 06/19/2025 at 1:50 PM, during an interview with the Director of Nursing (DON), She explained that CNAs are expected to follow the procedure for peri-care. She stated that improper care can lead to skin irritation and Urinary Tract Infections (UTIs).

A record review of Resident #9's Admission Record revealed an initial admission date of 4/26/2022 and a readmission date of 2/28/2025, with diagnoses including Acute Kidney Failure, Vascular Dementia, and Cognitive Communication Deficit.

A record review of Resident #9's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/6/2025 revealed a Brief Interview for Mental Status (BIMS) score of ninety-nine (99), indicating the interview was not completed. The MDS dated 6/4/25, Section GG revealed the resident is dependent on toileting and hygiene.

Resident #15

On 06/18/2025 at 4:29 PM, during an observation of peri-care for Resident #15 provided by CNA #3 and assisted by CNA #4 revealed CNA #3 placed a barrier on the bedside table. Both CNAs washed hands and applied clean gloves. CNA #3 removed the brief and began care. She wiped the front to back in the groin area on each side, then

Assurance (QA) Committee by the DON monthly times three (3) months to ensure compliance maintained beginning 7/25/25.

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F 690	Continued From page 8 wiped down the center of the labia one time. She did not wipe down the labial sides again. CNA #3 then sanitized hands, applied clean gloves, and continued care. On 06/18/2025 at 5:44 PM, during an interview with CNA #4, she confirmed that CNA #3 wiped down the center of the vagina only once. They stated proper care requires wiping each labial side front to back, then down the center. She acknowledged this failure could lead to a UTI. On 06/18/2025 at 5:49 PM, during an interview with CNA #3, she explained they were nervous and forgot to wipe down the sides. She acknowledged that this could result in a UTI for Resident #15. On 06/19/2025 at 1:55 PM, during an interview with the DON, She confirmed CNA #3 should have wiped each labial side and then the middle. She stated failure to do so could cause UTIs or infection and that staff are expected to follow the procedure as trained. A record review of Resident #15's Admission Record revealed an admission date of 7/8/2022, with diagnoses including Urinary Tract Infection and Alzheimer's Disease. A record review of Resident #15's MDS with an ARD of 3/26/2025 revealed a BIMS score of ninety-nine (99), indicating the interview was not completed. Section GG revealed the resident is dependent on toileting and hygiene.	F 690		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		7/27/25

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F 812	Continued From page 9 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, the facility failed to follow established guidelines for dating and labeling opened food items in the freezer and dry goods storage areas and failed to record food temperatures in the temperature log for breakfast during one (1) of four (4) survey days. This failure resulted in noncompliance with food safety standards and increased the risk of foodborne illness. Findings included: A review of the facility's policy, "Food Storage Labeling," revised February 2015, revealed, "The facility will ensure the safety and quality of food... 1 .All food items not in original package must be labeled...6.ii. Document the date the food is being	F 812	On June 16, 2025, all unlabeled and undated food items were disposed of by the Dietary Manager. The temperature log for breakfast was updated by the dietary cook to reflect the temperatures of food for breakfast on June 16, 2025. The Director of Nursing assessed residents on June 19, 2025 and reported no adverse reactions from this deficit practice. All residents that eat food from the Dietary Department have the potential to be affected	

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F 812	Continued From page 10 stored..." A review of the facility's policy, "Monitoring Food Temperatures," policy #FP.8, revised February 2015, revealed "...4. Storage temperatures should be recorded on the Cooked Food Storage Temperature Log..." A record review of an in-service training dated 4/28/2025 revealed that topics included labeling, dating, temperature taking, and recording. On 06/16/2025 at 10:18 AM, during the initial kitchen tour with the Dietary Manager, during an observation, the following was observed: In the freezer, one (1) open, unlabeled box of egg rolls and (1) repackaged but undated bag of biscuits were discovered. In the dry goods area, there was (1) package each of opened and repackaged white cake mix, brownie mix, blueberry muffin mix, gelatin mix, and a five (5)-pack of graham cracker crusts-all without open dates. The temperature log for breakfast on 6/16/2025 did not contain recorded temperatures. The Dietary Manager acknowledged and confirmed all findings at the time of inspection. On 06/17/2025 at 10:20 AM, during a phone interview with the Registered Dietitian (RD), explained that they were disappointed with the department's condition during the inspection. The RD stated that expectations were for kitchen staff include following procedures for opening, dating, and labeling stored food items. On 06/19/2025 at 2:30 PM, during an interview the Administrator, explained the expectations for the dietary department are to follow facility policies and standard precautions regarding food	F 812	by this deficit practice. The Dietary Manager was in-serviced on proper food storage labeling and monitoring and recording food temperatures by the Administrator on June 18, 2025. All dietary staff employees were in-serviced on proper food storage labeling and recording food temperatures on June 18, 2025 by the Dietary Manager. The Dietary Manager will make rounds three times a week for three weeks, then weekly for two months to monitor and ensure that food is being stored and labeled properly and temperatures are being recorded daily for each meal beginning June 18, 2025. The Dietary Manager will bring the results of the rounds to the Quality Assurance Committee monthly for three months beginning July 25, 2025 to assure continued compliance.	

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F 812	Continued From page 11 safety and handling.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		7/27/25

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	255192	A. BUILDING _____ B. WING _____	06/19/2025

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CLAIBORNE COUNTY SENIOR CARE	2124 OLD HWY 61 SOUTH PORT GIBSON, MS 39150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review the facility failed to provide incontinent care in a manner to prevent the possibility of cross-contamination for one (1) of four (4) peri-care observations (Resident #9). Findings included:	F 880	Residents #9 and #15 are receiving proper incontinent care as required. The Director of Nursing (DON) assessed residents #9 and #15 on 6/19/25 with no skin breakdown or signs of infection noted. All residents who require incontinent care have been assessed by DON or Infection Prevention (IP) Nurse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 13 A review of the facility's policy, "Infection Prevention and Control Program," with a revision date of August 2017, revealed, "It is a policy of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infection." During an observation of peri-care on 06/17/2025 at 2:10 PM, for Resident #9 provided by Certified Nursing Assistant (CNA) #1 and assisted by CNA #2 revealed CNA #1 placed items on the nightstand beside the bed without a barrier in place. Both CNAs washed their hands and applied clean gloves. CNA #1 pulled out four wipes and cleaned the vaginal area front to back, pulling wipes from the pack a total of four times while wearing soiled gloves. Resident #9 had feces in the back of her brief. CNA #1 then removed gloves, sanitized hands, and continued care in the buttocks area, again pulling wipes from the pack four additional times after starting care with contaminated gloves. During an interview on 06/17/2025 at 2:23 PM, CNA #2, She explained that CNA #1 pulled additional wipes from the pack while still wearing dirty gloves. During an interview on 06/17/2025 at 2:31 PM, CNA #1, acknowledged that wipes should not have been pulled from the pack with soiled gloves. She confirmed a barrier was not used on the bedside table and that all needed wipes should have been removed prior to beginning care. She stated this was an infection control issue.	F 880	between 6/20/25 and 6/23/25 with skin breakdown or signs of infection noted. All residents who require incontinent care have the potential to be affected by this deficient practice. Certified Nurse Aides (CNA'S) #1, #2 #3 and #4 were in-serviced between 6/20/25 and 6/23/25 on their next scheduled workday in a one-on-one meeting with IP nurse and DON. Skills were demonstrated per the IP nurse and a return demonstration was provided by each CNA. All CNA's were in-serviced on incontinent care by the IP Nurse and DON between 6/20/25 and 6/24/25 with demonstrations, videos with return demonstrations performed by all participants. CNA's were able to verbalize the effects of performing incontinent care that was unsatisfactory such as skin breakdown, the risk of urinary tract infections and uncleanliness. The IP nurse, Staff development nurse and DON will monitor incontinent care on three (3) residents, three (3) times weekly times six (6) weeks then three (3) residents weekly times six (6) weeks beginning 6/20/25 to ensure incontinent care is performed properly. Findings of monitors will be brought to the Quality Assurance (QA) Committee by the DON monthly times three (3) months to ensure compliance maintained beginning 7/25/25.	

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F 880	Continued From page 14 During an interview on 06/18/2025 at 5:08 PM, Registered Nurse (RN) #1/Infection Preventionist (IP), explained that peri-care should be performed by two people: one clean and one dirty. She stated the clean person should pull out wipes for the dirty person to avoid contamination. She reported that improper peri-care can lead to infection and skin breakdown. During an interview on 06/19/2025 at 1:50 PM, the Director of Nursing (DON) stated CNAs are expected to follow established procedures for peri-care. She confirmed that Resident #9 could develop skin irritation and a urinary tract infection (UTI) due to the improper technique used. She reported that CNA #1 should have placed a barrier and removed wipes prior to beginning care. A record review of Resident #9's Admission Record revealed an initial admission date of 4/26/2022 and a readmission date of 2/28/2025, with diagnoses including Acute Kidney Failure, Vascular Dementia, and Cognitive Communication Deficit. A record review of Resident #9's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/6/2025 revealed a Brief Interview for Mental Status (BIMS) score of ninety-nine (99), indicating the interview was not completed. The MDS, dated 6/4/25, Section GG revealed the resident is dependent on toileting and hygiene.	F 880		