STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **11/18/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NESHOBA COUNTY NURSING HOME	**1001 HOLLAND AVENUE , PHILADELPHIA, Mississippi, 39350**

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M0000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 09/29/25 to 10/02/25. During the survey, the SA determined the facility was in compliance with the Minimum Standards of Operations for Alzheimer's Disease/Dementia Care unit and there were no deficiencies cited. The census at the time of the survey was 20 with a bed capacity of 20.	M0000		
M0000	Initial Comments The State Agency (SA) conducted an annual re-certification survey at the facility from 9/29/25 through 10/02/25. During the survey, the SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institution for the Aged or Infirm. The SA identified non-compliance and cited M190, M610, M640, M655, M705, M815, M850, and M1570 for the annual certification. The census at the time of the survey was 128 and the facility is licensed for 145 beds.	M0000		
M0190	45.2.33 Restraint Restraint. The term "restraint" shall include any means, physical or chemical, which is intentionally used to restrict the freedom of movement of a person. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, interview, record review and facility policy review, the facility failed to ensure that the use of a bed alarm did not constitute a physical restraint for one (1) of four (4) residents reviewed for restraints (Resident #62). Findings Include:	M0190		

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

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M0190	Continued from page 1 Review of the facility policy titled," Restraint Free Environment" with an approval date of 6/27/2025 revealed, "Each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience, and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints." An observation and interview on 9/29/25 at 1:15 PM with Resident #62, revealed the resident lying in bed with her hands clenched, body appearing stiff and her bed alarm was sounding despite only slight movement. She stated, "If I misbehave, this thing beeps, I have to be still." The alarm kept sounding and Licensed Practical Nurse (LPN) #5. entered the room and adjusted the bed alarm without success. She removed it and placed another one. When asked about the reason for the bed alarm, she stated, "She falls a lot." During an interview on 9/30/25 at 11:06 AM with the Director of Clinical Services, she stated the bed alarm was in place so that the staff could hear her try and get up and they could assist her so that she would not fall. She stated, "The bed alarm should not restrain them or keep them from moving freely and that she was unaware her bed alarm was sounding at the slightest movement." On 9/30/25 at 2:40 PM, an interview with Resident #62, she stated, "I dislike the alarm immensely." She revealed that it wakes her up during the night when it sounds and scares her. Record Review of the "Bed Alarm Assessment" for Resident #62 revealed it was conducted on 9/03/2025. Record Review of the" Use of bed/chair alarm Informed Consent" for Resident #62 revealed the consent was signed on 12/16/24. Record review of Resident #62's demographic information revealed that the facility admitted resident on 11/15/2023 with a medical diagnosis that included Dementia. Record review of Resident #62's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/20/25 revealed under section C, a Brief Interview for Mental Status "BIMS" score of 03 which indicated that the resident was severely cognitively impaired.	M0190		
M0610	45.21.2 Activities of daily living	M0610		

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M0610	Continued from page 2 Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, interview, record review, and facility policy review, the facility failed to provide Activities of Daily Living (ADL) care related to nail care (Resident #64, Resident #105) and shaving (Resident #5) for 3 (three) of twenty-five sampled residents. Findings Include: Review of the facility policy titled "Activities of Daily Living" revealed under "Policy Explanation and Compliance Guidelines:...3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene…" Resident #5 On 9/29/25 at 3:38 PM and again on 9/29/25 at 3:58 PM Resident #5 was observed with multiple scattered gray chin hairs that measured approximately one-half (½) inch. She was pleasantly confused and unable to answer simple questions. On 09/30/25 at 2:38 PM, an observation and interview with Resident #5 and Licensed Practical Nurse (LPN #1) confirmed that the resident had multiple gray hairs on her chin. She admitted that the resident's facial hair should have been removed when she received her bath and that Certified Nurse Assistants (CNA) were supposed to assess facial hair as part of their personal hygiene but that this was not done.	M0610		

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M0610	Continued from page 3 On 09/30/25 at 4:11 PM, an interview with the Director of Nursing (DON) stated that she expected residents to be well groomed and that includes facial hair." She confirmed that the CNAs were supposed to remove facial hair on the resident's shower days. On 10/02/25 at 8:25 AM, an interview with CNA #1 confirmed that they were supposed to assess residents during their bath and if we see facial hair, we take care of it. She admitted that Resident #5 was bad to have facial hair and wouldn't want to be seen that way. She stated that Resident #5 should not be presented in public around other residents with that facial hair. On 10/02/25 at 8:30 AM, an interview with LPN #2, confirmed that personal hygiene included removal of facial hair and if women have peach fuzz or any facial hairs, we are supposed to take care of it. LPN #2 also stated, "I don't want to walk around with a beard being a woman". Record review of Resident #5's "Removal of Facial or Bodily Hair Consent" revealed that the consent was signed allowing the staff to shave her face/body hair and was signed on 11/19/24. Record review of Resident #5's "Profile History Report" revealed that under "ADLS", to ensure facial hair is removed as needed. Record review of Resident #5's demographic information revealed that the facility admitted the resident on 11/19/24 with diagnoses that included Alzheimer's, Unspecified Dementia, and Insomnia. Record review of Resident #5's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/06/25 under Section C revealed a BIMS score of 03 which indicated that she had severe cognitive deficits. Resident #64 An observation on 9/29/25 at 2:35 PM and again on 9/30/25 at 2:55 PM of Resident #64 revealed the resident lying in bed with long, thumb nails, approximately one-eighth (1/8) in length, jagged with a brown substance underneath and his hands were closed into a fist. An observation and interview on 9/30/25 at 3:00 PM at Resident #64's bedside with the Director of Clinical Services confirmed the resident's thumb nails were long	M0610		

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M0610	Continued from page 4 and dirty. She opened his hands and revealed that all his fingernails were long with a brown substance underneath. No broken skin was observed on either hand. She stated, "If his nails are not kept trimmed and clean, he could easily get a break in his skin and develop an infection." On 10/01/25 at 9:00 AM the DON was interviewed regarding the facility's expectations for fingernail care. The DON stated, " Staff are expected to keep residents' fingernails trimmed and clean. Long or dirty nails could cause a break in the skin and lead to infection." Record review of Resident #64's demographic information revealed that the facility admitted resident on 2/11/19 with a medical diagnosis that included Anoxic brain injury. Record review of the MDS with an ARD of 7/14/25 revealed under Section C that cognitive skills for daily decision making were severely impaired. Resident #105 On 09/29/25 at 1:10 PM and again on 09/30/25 at 2:53 PM, Resident 105 was observed with long fingernails on both hands that were approximately half of an inch long past the fingertips. On 09/30/25 at 2:55 PM, an observation and interview with LPN #1 confirmed that Resident #105's fingernails were long and needed trimming. She revealed that long fingernails could cause skin tears and possible skin infections. She admitted that Resident #105 was on the schedule for his nails to be clipped every Friday on the day shift and she confirmed that his fingernails had not been clipped in a while. On 09/30/25 at 4:09 PM, an interview with the DON confirmed that the CNA's were supposed to check fingernails and clip them if needed unless the resident was a diabetic. She revealed that fingernail care was supposed to be done weekly on every resident as part of their personal hygiene and grooming needs and expected residents to be well-groomed which included nail care. Record review of Resident #105's demographic information revealed that the facility admitted the resident on 03/06/25 with diagnoses that included Left Hemiplegia, Acute Brainstem Stroke, and Dementia. Record review of Resident #105's MDS with an ARD of	M0610		

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M0610	Continued from page 5 08/27/25 revealed under Section C a BIMS Score of 03 which indicated that he had severe cognitive deficits.	M0610		
M0640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure that a resident identified as at risk for elopement was wearing the physician prescribed wander alert bracelet for one (1) of four (4) residents reviewed for accident hazards. Resident #57 Findings Include: Review of the facility policy titled “Code Alert Policy,” unrevised, revealed under Policy: “To prevent wandering residents from leaving the facility or attempting to leave the facility by alerting the nursing staff of their exit through the doors... Procedure: Wandering residents who are deemed to be a Flight Risk will have a code alert bracelet placed on their wrist or ankle…The staff nurse will check each transmitter and the door each shift and document on the code alert TAR (treatment administration record) in the EHR (electronic health record) if the transmitters and doors are functioning correctly...” An observation and interview with Resident #57 on 9/29/25 at 12:40 PM revealed she was sitting in her recliner in her room reading a book with a wander alert bracelet lying on a book shelf. Resident #57 stated, “That’s something somebody gave me.” An observation of Resident #57 on 9/30/25 at 9:42 AM revealed she was again in her recliner reading and the wander alert bracelet remained on the book shelf. Record review of Resident #57’s “Physician Orders” revealed an order dated 10/14/24: “Code Bracelet/Wander	M0640		

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M0640	Continued from page 6 Alert TAR (treatment administration record) BID (twice daily), code alert, ensure code alert is intact." An observation and interview with Registered Nurse (RN) #1 on 9/30/25 at 2:36 PM revealed Resident #57 was supposed to be wearing a wander alert bracelet because she had Alzheimer's disease and was ambulatory. RN #1 stated Resident #57 had the bracelet for her safety so she would not get out of the facility. During the observation with Resident #57, RN #1 confirmed the resident did not have the bracelet on and stated the nurses were responsible for checking the placement of the device twice daily and documenting it under the task section in the medical record. An interview with the Director of Nursing (DON) on 9/30/25 at 4:06 PM confirmed Resident #57 was at risk for elopement by not wearing the wander device as ordered. Record review of Resident #57's demographic information revealed the facility admitted the resident on 10/14/24 with medical diagnoses that included Alzheimer's Disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/26/25 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 3, indicating Resident #57 was severely cognitively impaired.	M0640		
M0655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, staff interview, and facility policy review, the facility failed to ensure proper placement of a gastrostomy tube prior to medication administration for one (1) of two (2) enteral tubes reviewed. Resident #64	M0655		

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M0655	Continued from page 7 Review of the facility policy titled “Enteral Tube Medication,” unrevised, revealed under Policy Explanation and Compliance Guidelines: “8. Enteral tube placement must be checked via auscultation and/or aspiration before any fluids or medication are administered.” During an observation on 9/30/25 at 12:10 PM with Resident #64, Licensed Practical Nurse (LPN) #5 flushed the resident’s enteral tube with water and administered medications without first verifying placement of the tube. An interview with LPN #5 on 9/30/25 at 12:21 PM confirmed that she did not check placement of Resident #64’s enteral tube prior to administering medications and that it should have been done to ensure the tube was in the proper place to prevent aspiration. She admitted that the nursing staff was supposed to follow standards of practice by aspirating gastric contents of the tube to verify placement. An interview with the Director of Nursing (DON) on 9/30/25 at 4:02 PM confirmed enteral tube placement should be verified prior to flushes or medication administration to ensure the tube had not migrated, which could lead to aspiration. Record review of Resident #64’s demographic information revealed the facility admitted resident on 1/23/19 with medical diagnoses that included Anoxic Brain Injury and that the resident receives feedings through a gastrostomy.	M0655		
M0705	45.24.2 Policies and procedures Policies and procedures. Each facility shall have policies and procedures to assure the following: 1. Accurate acquiring; 2. Receiving; 3. Dispensing; 4. Storage; and	M0705		

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M0705	Continued from page 8 5. Administration of all drugs and biologicals. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to ensure the safe storage and security of medications for one (1) of 128 residents reviewed during initial tour. Resident #101 Findings Include: Review of the facility policy titled “General Rules for Residents and Sponsors” (undated) revealed under section .5: “Residents are not permitted to keep any medications in their room unless the interdisciplinary team has determined that this practice is safe and ordered by the physician.” An observation and interview with Resident #101 on 9/29/25 at 12:42 PM revealed she was lying in bed with a Symbicort inhaler and a Spiriva inhaler lying on a table in the room. Resident #101 stated the nurse had forgotten to come back and get them after she took them that morning. Record review of the “Medication Administration Record (MAR)” revealed an order dated 7/14/25, “Tiotropium (Spiriva Respimat) 1.25 mcg(microgram)/INH (inhalation aerosol), inhale 2 puffs daily.” The MAR also revealed an order dated 7/22/24, “Budesonide-formoterol 80 mcg (microgram)– 4.5 mcg(microgram)/INH (inhalation aerosol), inhale 1 puff BID (twice daily).” An interview with Registered Nurse (RN) #1 on 9/30/25 at 2:30 PM revealed Resident #101 did not have an order to self-administer medications. RN #1 stated the nurse should always remain in the room and watch the resident take the medication appropriately, and medications should never be left unattended. She explained that leaving medications in the room could result in the resident taking too much or another resident gaining access to the medication. An interview with Licensed Practical Nurse (LPN) #3 on 9/30/25 at 2:49 PM confirmed she was responsible for	M0705		

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M0705	Continued from page 9 leaving the inhalers in Resident #101's room. She explained she had to step next door to assist another resident and left the medications on the TV stand. LPN #3 acknowledged that leaving medications at the bedside could harm Resident #101 if she took too much or could pose a risk if another resident accessed the medication. An interview with the Director of Nursing (DON) on 9/30/25 at 4:00 PM revealed her expectations were that all medications must be securely stored in the medication carts and never left in a resident's room. Record review of Resident #101's demographic information revealed the facility admitted resident on 8/17/20 with a medical diagnosis that included Atherosclerotic Heart Disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/10/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 13, indicating Resident #101 was cognitively intact.	M0705		
M0815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Widespread Based on observation, interview, record review, and facility policy review, the facility failed to ensure the kitchen equipment and surrounding areas were maintained in a clean and sanitary condition for two (2) of three (3) kitchen tours. Findings Include Record review of the facility policy titled, "General Sanitation of the Kitchen" undated, revealed the staff shall maintain the sanitation of the kitchen through compliance with a written comprehensive cleaning schedule. …4. A cleaning schedule will be posted. Employees will be trained on the cleaning schedule and how to perform duties. Employees will initial and date tasks when completed..."	M0815		

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M0815	Continued from page 10 During the initial kitchen tour on 9/29/25 at 12:20 PM, observation of the deep fryer revealed a thick yellow and black substance with food particles built up down the entire right side of the fryer. The left side of the stove had splattered buildup, and underneath the fryer was a thick, greasy substance with food particles extending across the surrounding floor. On 10/01/25 at 9:15 AM, during an interview and concurrent observation, the Dietary Manager (DM) revealed that fryer oil is to be changed weekly and that the fryer's exterior is to be cleaned at that time, with staff required to initial and date the task upon completion. The DM confirmed that the fryer's right side had thick yellow and black buildup with food particles, and the left side of the stove had splattered buildup. He stated, "It looks like it has not been cleaned in a while." The DM further confirmed the greasy buildup underneath and around the fryer should have been mopped and acknowledged that cleaning the floors was not currently included in the cleaning schedule, but should be, to ensure completion. On 10/01/25 at 9:25 AM, an interview and review of the "Weekly Cleaning Schedule" for September 2025 with the DM revealed initials indicating fryer cleaning was completed. The DM confirmed that the fryer cleaning task specifies "Interior/Exterior." He acknowledged, "I can see where this could be just initialed as done without it actually being done, because obviously by the looks of things we can see that it was not cleaned like it should have been and that is unacceptable." On 10/01/25 at 9:30 AM, an interview with Dietary Supervisor (DS) #1 stated that cleaning the floors is everyone's responsibility, even if not listed on the schedule, and confirmed that the greasy buildup under the fryer and the dirty fryer and stove were not acceptable. She stated the kitchen should always be kept clean and sanitary. During an interview on 10/01/25 at 3:45 PM, the Administrator (ADM) revealed that the expectation is that the kitchen where resident meals are prepared is always kept clean and sanitary to prevent any potential foodborne illness.	M0815		
M0850	45.30.6 Modified Diets	M0850		

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M0850	Continued from page 11 Modified Diets. Modified diets which are a part of medical treatment shall be prescribed in written orders by the physician or nurse practitioner/physician assistant. All modified diets shall be planned in writing and posted along with regular menus. Liberalized Geriatric Diets are encouraged for elderly residents when there is a need for moderate diet therapy. A current diet manual shall be available to personnel. The dietitian shall approve all modified diet menus and the diet manual used in the nursing home. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, interview, record review, and facility policy review, the facility failed to provide a prescribed therapeutic diet for one (1) of 26 sampled residents. Resident #134. Findings Include: Review of the facility policy titled, “Thickened Liquids" revealed, "It is the policy of the (proper name) facility that residents receive liquids as they are ordered and recommended by their physician and or speech language pathologist. An observation and interview on 09/30/25 at 11:32 AM of Resident #134's lunch meal revealed that he had nectar thickened water, nectar thickened sweet tea, and a carton of regular consistency creamy strawberry Glucerna on his tray. An observation also revealed Certified Nursing Assistant (CNA) #2, open his Glucerna and insert a straw into the container for him to drink. CNA #2 confirmed that the Glucerna was not nectar consistency like the water and sweet tea. During an observation and interview on 09/30/25 at 11:36 AM in Resident #134's room with Registered Nurse (RN) #1, she confirmed that the Strawberry Glucerna that was on Resident #134's meal tray was regular consistency. She revealed that not providing his prescribed nectar thickened liquids could cause him to choke and aspirate. She also confirmed that Resident #134's meal ticket on his tray showed that he was supposed to be getting thickened Glucerna with his meal. RN #1 removed the Glucerna from Resident #134's tray and left the room. An interview on 09/30/25 at 4:05 PM with the Director of Nursing (DON), revealed that Resident #134's meal was supposed to come from the kitchen ready to consume	M0850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **11/18/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M0850	Continued from page 12 and this included the addition of thickener to his Glucerna. She also confirmed that by not providing Resident #134 with the thickened Glucerna, this could result in aspiration and lead to respiratory problems. An interview on 10/01/25 at 9:40 AM with the Dietary Manager (DM) confirmed that Resident #134 should have received thickened Glucerna from the kitchen. He also confirmed that all staff who prepared resident plates for meals were supposed to look at meal tickets and make sure they matched what was on the trays. He admitted that it was ultimately the responsibility of the Dietary Supervisor to ensure that a resident received the proper prescribed diet. An interview on 10/01/25 at 11:05 AM with the Dietary Supervisor (DS) #2 confirmed that Resident #134 should have received nectar thickened Glucerna yesterday and by not receiving the prescribed diet, he could have gotten strangled. She revealed that when a resident had a meal ticket that included Glucerna (thickened), they were supposed to pour the Glucerna in a separate glass and add thickener to it to make the right consistency. She admitted that everyone on the serving line was supposed to check to ensure the meal ticket orders matched what they served. Dietary Supervisor #2 added that she normally caught those mistakes and stated, "I just missed it yesterday." Record review of Resident #134's meal ticket dated 09/30/25, revealed that he was ordered to have a Mechanical Soft, Nectar Thick Diet and this included Glucerna (Thicken) on his meal tray. Record review of Resident #134's "Physician Order Review" revealed a diet order dated 09/24/25 for nectar/mildly thick beverage, Glucerna with L/S (Lunch/Supper). Aspiration Precautions Needed. Record review of Resident #134's "Face Sheet" revealed an admission date of 09/24/25 and that he had diagnoses that included Right Thalamic Infarction, Stroke, and Communication Impairment. Record review of Resident #134's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 03/12/25 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated that he had no cognitive deficits.	M0850		
M1570	48.58.1 Infection Control The following infection control standards shall be met:	M1570		

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M1570	Continued from page 13 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observations, interviews, record review and facility policy review, the facility failed to ensure the possibility of the spread of infection by respiratory equipment not being stored properly for one (1) of two (2) residents observed receiving nebulizer treatments (Resident # 53) Findings Include Review of the facility policy titled "Nebulizer Therapy" with an approval date of 8/06/25 revealed, "It is the policy of this facility for nebulizer treatments, once ordered, to be administered by nursing staff as directed using proper technique and standard precautions." An observation on 9/29/25 at 4:30 PM and again on 9/30/25 at 1:45 PM revealed Resident #53's nebulizer was sitting on top of the resident's oxygen concentrator with the mouthpiece uncovered and not stored in a clean or protected manner. During an observation and interview with the Clinical Services Director on 9/30/25 at 3:30 PM, she confirmed that Resident # 53's mouthpiece was not stored	M1570		

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M1570	Continued from page 14 properly. She stated that "It should be covered, stored in a clean bag or container because leaving it out like that could cause an infection." On 10/01/25 at 10:15 AM an interview with the Director of Nursing (DON) confirmed that nebulizer mouthpieces should always be stored in a bag to prevent contamination. Record Review of "LTC Physician Order Review/Renewal" reveals Resident #53 has an order for Ipratropium-Albuterol 3 mL (milliliters) Inhale solution two times a day as needed for wheezing. Record review of the "Face Sheet" revealed that the facility admitted Resident #53 on 9/15/2022 with a medical diagnosis that Airway-centered interstitial fibrosis. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/01/25 revealed under section C, a Brief Interview for Mental Status (BIMS) score of 12 which indicated Resident #64 was moderately cognitively impaired.	M1570		