STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255097	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CENTER OF ABERDEEN	**505 JACKSON ST , ABERDEEN, Mississippi, 39730**

(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
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility on 05/04/26 through 05/06/26. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F641, F656, F658, F677, F692 and F812. The facility had a census of 89 and was licensed for 105 beds.	F0000		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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, staff interview, and facility policy review, the facility failed to ensure food items in the kitchen were properly labeled and dated after	F0812		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0812 SS = F	Continued from page 1 opening and failed to maintain a clean refrigerator to prevent cross-contamination of stored foods during one (1) of two (2) kitchen tours. Findings Include: Review of the facility policy titled “Cleaning and Sanitizing Equipment,” revised 5/18, revealed under “Policy: All equipment is kept clean and food contact surfaces are cleaned and sanitized.” Review of the facility policy titled “Food Storage Labeling,” revised 8/12, revealed under “Policy: The facility will ensure the safety and quality of food by adhering to proper storage and labeling procedures.” Also revealed under “Procedure 1. Labeling a. All temperature-controlled foods and ready-to-eat foods that are prepared in the facility and held for longer than twenty-four hours will be labeled. Information included on the label: Name of the food, Date of storage.” Observations on 5/4/26 at 5:25 PM during the initial kitchen tour revealed Refrigerator #1 contained: - One (1) 5-pound container of open and undated pimento cheese spread - One (1) open package of boiled eggs containing five (5) eggs that was undated - One (1) open and undated carton of liquid whole eggs An observation of Freezer #1 revealed frozen fish fillets stored in a clear gallon zip-lock bag that was undated. An observation of the kitchen pantry revealed one (1) open five (5)-pound bag of Quick Grits that was unlabeled and not secured in a storage bag. An observation of Refrigerator #3 revealed numerous small circular black spots scattered throughout the interior back portion of the refrigerator, the left inner side panel, and three (3) refrigerator racks. The black spots varied in size and had a fuzzy texture. Also observed inside the refrigerator was a silver metal square container covered in aluminum foil that contained sliced onions without a label to determine the date of storage. An observation and interview with Dietary Staff #1 on 5/4/26 at 6:05 PM confirmed the black substance inside Refrigerator #3 and stated, “It looks like mold.” She stated the substance could contaminate the food and make a resident or staff member sick.	F0812		

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F0812 SS = F	Continued from page 2 She revealed the Dietary Manager was responsible for cleaning out the refrigerator. Dietary Staff #1 confirmed the undated items in the refrigerator, freezer, and pantry and stated the items should be discarded because there was no way to determine how long they had been stored. She stated the grits should have been secured in a bag in the storage room. She explained that any opened food items stored in the refrigerators, freezers, or pantry must be dated and stored appropriately to maintain freshness and food safety and to prevent illness. An observation and interview with the Dietary Manager (DM) on 5/4/26 at 6:40 PM confirmed the black substance inside Refrigerator #3. He stated it was the dietary aides' responsibility to clean the refrigerator. He confirmed the refrigerator was not clean and stated the substance could contaminate food items stored inside. He further confirmed all foods stored in the refrigerator, freezer, and pantry should be labeled and dated to ensure safe food consumption and prevent foodborne illness. An interview with the Administrator on 5/6/26 at 7:55 AM revealed opened food items in the kitchen should be labeled, dated, and stored appropriately and kitchen equipment should remain clean according to the equipment cleaning schedule to ensure food safety and prevent residents from becoming ill. She revealed it was the DM's responsibility to ensure this was done.	F0812		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F0641		

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F0641 SS = D	Continued from page 3 §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews, record review, and facility policy review the facility failed to accurately complete the Minimum Data Set (MDS) assessment, as evidenced by incorrectly coding during the 7-day observation look-back period for three (3) of nineteen sampled residents. Residents #3, Resident #7, and Resident #53 Findings Include: Record review of the facility policy titled, "Minimum Data Set Charting Documentation Guidelines", dated 11/25, revealed, "To have an accurate assessment of the residents, information must be gathered on the residents while in the observation period for the MDS. This information must come from resident assessment and documented information in the residents' chart within the time frames set forth on the MDS. To ensure that information is in the chart to validate information on the MDS the Charting Documentation guidelines should be utilized..." Record review of the facility policy titled, "MDS Process" revealed, "The Resident Assessment Instrument (RAI) Manual shall serve as the primary reference for MDS coding guidelines, scheduling requirements, and regulatory compliance." Resident #3 Record review of Resident #3's January 2026	F0641		

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F0641 SS = D	Continued from page 4 Medication Administration Record (MAR) revealed an active order for Rivaroxaban Oral Tablet 20 milligrams (MG), give 1 tablet by mouth in the evening, with a start date of 10/16/2025. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/12/26 revealed under Section N, Resident #3's anticoagulant medication was not coded. An interview with the MDS Nurse on 5/05/2026 at 3:40 PM, confirmed Resident #3 was on an anticoagulant and his quarterly MDS Assessment that was done on 01/12/26 was not coded correctly to reflect the anticoagulant he is receiving. Record review of the "Face Sheet" revealed Resident #3 was admitted to the facility on 12/28/2024 with diagnoses that included Paroxysmal Atrial Fibrillation and Presence of a Cardiac Pacemaker. Record review of the MDS with an Assessment Reference Date (ARD) of 01/12/26 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #3 was cognitively intact. Resident #7 Record review of Resident #7's "Order Summary Report" revealed an order dated 08/05/2025, "Admit to Hospice Services DX (diagnosis): COPD (Chronic Obstructive Pulmonary Disease)" Record review of the MDS with an ARD of 04/07/26, revealed under Section O, Resident #7 "Hospice Care" was not coded. An interview with the MDS Nurse on 5/06/2026 at 9:40 AM, confirmed Resident #7 was on hospice services and his quarterly MDS Assessment that was done on 4/7/2026 was not coded correctly to reflect the hospice services he is receiving. Record review of the "Face Sheet" revealed Resident #7 was admitted to the facility on 06/04/2021 with diagnoses that included Chronic Obstructive Pulmonary Disease, and Major Depressive Disorder.	F0641		

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F0641 SS = D	Continued from page 5 Record review of the MDS with an ARD of 04/07/26 revealed a BIMS score of 15 which indicated Resident #7 was cognitively intact. Resident #53 Record review revealed Resident #53's MDS with ARD of 04/08/26 Section N - Medications was marked seven (7) of 7 days for anticoagulant. Interview on 05/06/26 at 9:00 PM with the MDS nurse confirmed that the resident was not taking an anticoagulant medication and it was incorrectly coded for an anticoagulant. She stated that the resident was taking an antiplatelet and it was incorrectly coded as an anticoagulant. Record review of Resident #53's Face Sheet revealed he was admitted to the facility on 05/24/25 with diagnoses including Diabetes, Hypertension and Cardiac Murmur. Record review of Resident #53's MDS with an ARD of 04/08/26 revealed a BIMS score of 03 indicating severe cognitive impairment.	F0641		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F0656		

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F0656 SS = D	Continued from page 6 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interviews, record review, and facility policy review, the facility failed to ensure the feeding tube care plan was implemented for Resident #5 and an Activities of Daily Living (ADL) care plan was implemented for Resident #17 for two (2) of nineteen care plans reviewed. Resident #5 and #17. Findings Include: Review of the facility policy titled “Care Plan Process" with a revision date of 12/24, revealed "Regulations require facilities to complete, at a minimum and at regular intervals, a comprehensive, standardized assessment of each resident's functional capacity and needs, in relation to several specified areas (e.g., customary routine, vision, and continence)." Resident #5	F0656		

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F0656 SS = D	Continued from page 7 Record review of Resident #5's "Care Plan Report" revealed "The resident requires tube feeding related to (r/t) resisting eating... Interventions... Diabetasource @ 59 ml(milliliters)/hr(hour) for 24 hours..." with a revision date of 2/23/2026. Record review of the “Order Summary” revealed an order dated 02/23/2026 for “Enteral Feed Order … Diabetasource @ 59 ml(milliliters)/hr(hour) for 24 hours to include 1700 kcals (kilocalories), 88 grams of protein, and 1189 ml of fluid.” On 5/04/2026 at 5:36 PM an observation revealed Resident #5’s enteral feeding pump was paused and actively beeping. On 5/04/2026 at 5:45 PM, during an observation and interview Certified Nurse Aide (CNA) #1 was observed feeding Resident #5 a mechanically chopped meal. CNA #1 revealed the resident receives pleasure trays, which was why the feeding pump had been turned off. CNA #1 further revealed she did not know how long the feeding had been off. On 5/06/2026 at 1:30 PM, Resident #5 was observed sitting in the front foyer without his tube feeding infusing. A subsequent observation on 5/06/2026 at 1:52 PM again revealed Resident #5 sitting in the front foyer without the enteral feeding pump infusing. During an interview on 5/6/2026 at 3:55 PM, the Minimum Data Set (MDS) Nurse confirmed Resident #5's care plan and physician's order were for his enteral feedings to be continuously infusing and further revealed if he was not getting his feedings then his plan of care was not being followed and it should have been. Record review of the "Face Sheet" revealed Resident #5 was admitted to the facility on 11/13/2019 with diagnoses that included Encounter for Attention to Gastrostomy, Type 2 Diabetes Mellitus, and Unspecified Sequelae of Cerebral Infarction. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/11/26 revealed a Brief Interview for Mental Status (BIMS) score of 01 which indicated Resident #5 was severely cognitively impaired. Resident #17 Record review of the Care Plan Report for Resident	F0656		

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F0656 SS = D	Continued from page 8 #17 revealed "Resident needs assist with ADLs…Interventions…Bathing: Observe nail length, clean on bath day and as needed…Personal Hygiene: The resident is dependent on staff for personal hygiene. Nail Care-clean, cut and file nails. Date Initiated 11/19/2024…" Observations on 5/4/2026 at 5:48 PM, 5/5/2026 at 8:47 AM, and again on 5/6/2026 at 8:26 AM of Resident #17 revealed her fingernails were approximately one (1) inch in length with jagged edges and contained a dark brown/black substance underneath the nails. On 5/6/2026 at 8:30 AM during an observation and interview, Licensed Practical Nurse (LPN) #1 confirmed Resident #17's fingernails were long, jagged, and contained a dark brown/black substance underneath. She stated the resident's fingernails should have been trimmed during bathing or showering. She further stated long, jagged fingernails placed Resident #17 at risk for skin tears or scratches that could lead to infection. During an interview on 5/6/2026 at 10:04 AM, the MDS Nurse confirmed the ADL care plan for Resident #17 had been developed appropriately; however, the interventions were not implemented by facility staff. Record review of the Face Sheet indicated Resident #17 was admitted to the facility on 4/14/2020 with medical diagnoses that included Alzheimer's disease. Record review of the MDS, with an ARD of 3/3/2026, revealed under Section C that a BIMS was not conducted because Resident #17 was rarely or never understood.	F0656		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview and record review the facility failed to ensure blood sugar monitoring was provided in accordance with professional standards	F0658		

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F0658 SS = D	Continued from page 9 of practice for one (1) of five (5) residents who were reviewed for medication monitoring. Resident #94 Findings Include: Review of a statement typed on facility letterhead dated 5/6/26 and signed by the Administrator revealed, “The facility does not have a policy on insulin/glucose monitoring.” Record review of Resident #94's "Medication Administration Record (MAR)" with order date of 04/28/2026, revealed "Novolin 70/30 Flex Pen Subcutaneous Suspension Pen-Injector (70-30) 100 Unit/ml (milliliter) (Insulin NPH Isophane & Reg (Human) Inject eight (8) units subcutaneously two times a day." Record review of Resident #94’s “Medication Administration Record” revealed no documentation of monitoring blood sugar. Record review of “Blood Sugar Summary” revealed Resident #94’s blood sugar was checked on 4/28/2026 and 4/29/2026. On 5/6/2026 at 10:45 AM an interview with the Director of Nursing (DON) confirmed that blood sugars should be monitored when a resident has an order for insulin. The DON revealed the house supervisor is responsible for putting in admission orders. He stated when entering an order, there was a place to add a supplementary task to check the blood sugar. The DON confirmed that the house supervisor failed to add the supplementary task when the insulin order was entered. Record review of the “Face Sheet” revealed the facility admitted Resident #94 on 4/28/2026 with medical diagnoses including Diabetes Mellitus Due To Underlying Condition with Diabetic Neuropathy. Record review of “Interviews - V 4" dated 4/28/26 revealed a Brief Interview for Mental Status (BIMS) summary score of 10 which indicated Resident #94 was moderately cognitively impaired.	F0658		

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F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff interviews, record review, and facility policy review, the facility failed to provide activities of daily living (ADL) care necessary to maintain personal hygiene for one (1) of 89 residents observed. Resident #17 Findings include: Review of the facility policy titled “Activities of Daily Living,” with a review date of 9/2025, revealed, “…ADLs shall include, but are not limited to personal hygiene, bathing, voiding, toileting, repositioning, and meals offered…” On 5/4/2026 at 5:48 PM, 5/5/2026 at 8:47 AM, and again on 5/6/2026 at 8:26 AM, observations of Resident #17 revealed her fingernails were approximately one (1) inch in length with jagged edges and contained a dark brown/black substance underneath the nails. During an observation and interview on 5/6/2026 at 8:30 AM, Licensed Practical Nurse (LPN) #1 confirmed Resident #17’s fingernails were long, jagged, and contained a dark brown/black substance underneath. She stated the resident’s fingernails should have been trimmed during bathing or showering. She further stated long, jagged fingernails placed Resident #17 at risk for skin tears or scratches that could lead to infection. During an interview on 5/6/2026 at 8:45 AM, the Director of Nursing (DON) stated all residents’ fingernails should be kept trimmed and clean. He stated fingernails should be checked during bathing or showering but may be trimmed whenever needed. He further stated long, jagged fingernails could easily cause skin tears, which could lead to infection. Record review of the Admission Record indicated Resident #17 was admitted to the facility on 4/14/2020 with medical diagnoses that included Alzheimer’s disease. Record review of the Minimum Data Set (MDS), with	F0677		

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F0677 SS = D	Continued from page 11 an Assessment Reference Date (ARD) of 3/3/2026, revealed under Section C that a Brief Interview for Mental Status (BIMS) was not conducted because Resident #17 was rarely or never understood.	F0677		
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure physician-ordered continuous enteral feedings were consistently administered for one (1) of two (2) residents reviewed for tube feeding management. Resident #5 Findings Include: Review of the facility policy titled “Tube Feedings” with a revision date of 12/15 revealed, “1. All tube feedings will be administered in accordance with verified medical necessity, established infection control policies and procedures and physician's orders...” Record review of the “Order Summary” revealed an order dated 02/23/2026 for “Enteral Feed Order…Diabetasource at 59 ml (milliliters) /hr (hour) for 24 hours to include 1700 kcals (kilocalories), 88	F0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255097	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CENTER OF ABERDEEN	505 JACKSON ST , ABERDEEN, Mississippi, 39730

(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
F0692 SS = D	Continued from page 12 grams of protein, and 1189 ml of fluid." An observation on 5/04/2026 at 5:36 PM revealed Resident #5's enteral feeding pump was paused and actively beeping. During an observation and interview on 5/04/2026 at 5:45 PM, Certified Nurse Aide (CNA) #1 was observed feeding Resident #5 a mechanically chopped meal. CNA #2 revealed the resident receives pleasure trays, which was why the feeding pump had been turned off. CNA #1 further revealed she did not know how long the feeding pump had been off. During an observation on 5/06/2026 at 1:30 PM, Resident #5 was observed sitting in the front foyer without his tube feeding infusing. A subsequent observation on 5/06/2026 at 1:52 PM again revealed Resident #5 sitting in the front foyer without the enteral feeding pump infusing. During an interview on 5/06/2026 at 1:57 PM, Licensed Practical Nurse (LPN) #2 revealed Resident #5 received Diabetisource at 59 ML per hour through his Percutaneous Endoscopic Gastrostomy (PEG) tube and also received pleasure trays for all meals. LPN #2 stated the resident frequently preferred to sit in the front foyer and revealed she was unsure whether the feeding pump should be brought into the foyer due to the amount of foot traffic through the area. LPN #2 confirmed the resident had a physician's order for continuous tube feeding and acknowledged that the resident's nutritional needs were not being met as ordered when the feeding was not infusing. During an interview on 5/06/2026 at 2:45 PM, the Director of Nursing (DON) revealed Resident #5 had gained three pounds from January to February, and the Registered Dietitian had recommended changing the resident's continuous feeding to bolus feedings four times daily; however, the physician declined the recommendation and ordered the resident to remain on continuous feedings in addition to pleasure trays. The DON confirmed Resident #5 should have remained connected to the feeding pump regardless of his location within the facility and acknowledged that failure to administer the feeding as ordered placed the resident at risk for weight loss and inadequate nutritional intake. Record review of the "Face Sheet" revealed Resident #5 was admitted to the facility on 11/13/2019 with diagnoses that included Encounter for Attention to Gastrostomy, Type 2 Diabetes Mellitus, and	F0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255097	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0692 SS = D	Continued from page 13 Unspecified Sequelae of Cerebral Infarction. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/11/26 revealed a Brief Interview for Mental Status (BIMS) score of 01 which indicated Resident #7 was severely cognitively impaired.	F0692		