

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255347	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/30/2026
NAME OF PROVIDER OR SUPPLIER Choctaw Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 311 West Cherry Street Ackerman, MS 39735	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and facility policy review, the facility failed to maintain the kitchen in a sanitary condition in order to serve and prepare food for one (1) of two (2) kitchen tours. Findings Include: Review of the facility policy titled Sanitary Conditions of the Food Service Department with an originated date of 9/04, revealed the following policy statement, Facilities and equipment used in the preparation and serving of food provided to residents are safe and sanitary. During the initial kitchen tour on 6/28/2026 at 2:20 PM with Dietary #1, Dietary #2, and Dietary #3, observations were made regarding the cleanliness of the kitchen environment. The pantry door frame facing the kitchen contained accumulated dirt and dried food residue. Above the left side of the door frame on the ceiling contained multiple dried food splatter marks, approximately six (6) inches in diameter. Dietary #3 stated, That's been there forever. Further observation revealed the vent hood above the cooking area contained accumulated grease and food residue on the lower portion of the structure. Dietary #1 confirmed the buildup could flake off into food during meal preparation and confirmed that it needed to be cleaned. During an interview on 6/29/2026 at 10:45 AM, the Certified Dietary Manager (CDM) confirmed the food residue and dirt observed on the ceiling, door frame, and vent hood had been cleaned after the initial observation. The DM stated the conditions observed were not consistent with facility's expectations for maintaining a clean kitchen environment and that this was in a food prep and serve area. During an interview on 6/29/2026 at 2:45 PM with the Administrator, she stated it is the facility's expectation that the kitchen be maintained in a clean and sanitary condition.		

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 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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 255347	Facility ID: 255347
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to accurately complete Section P of the Minimum Data Set (MDS) assessment related to alarms for one (1) of 19 residents reviewed for MDS accuracy. Resident #9 Findings Include: The facility provided a statement on letterhead that read, We do not have a policy concerning accuracy of MDS. We do however follow the guidance of the MDS RAI (Resident Assessment Instrument) manual. Record review of Resident #9's Physician Order revealed an order dated 7/18/25, Ensure chair alarm is turned on and functioning properly. Record review of Resident #9's MDS with an Assessment Reference Date (ARD) of 5/19/26 revealed Item P0200 did not identify the resident's use of a wheelchair alarm during the assessment reference period. An interview with the MDS Nurse on 6/30/26 at 1:10 PM confirmed Resident #9 had a wheelchair alarm during the May assessment reference period and acknowledged it should have been coded in Item P0200 of the MDS. She stated, I just missed it. She further revealed the MDS should be accurate to provide an individualized picture of the resident. Record review of the admission Record revealed the facility re-admitted Resident #9 on 7/26/24 with medical diagnoses that included Parkinson's Disease without Dyskinesia and Hemiplegia Unspecified Affecting left Nondominant Side. Record review of the MDS with an ARD of 5/19/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #9 was cognitively intact.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, record review, and facility policy review, the facility failed to develop and implement comprehensive, person-centered care plans for two (2) of nineteen (19) residents reviewed for care planning. The facility failed to develop a comprehensive care plan addressing urinary catheter care for one (1) resident (Resident #1) and failed to implement the established care plan related to diabetic nail care for one (1) resident (Resident #15). Findings include: Review of facility policy titled Comprehensive Care Plan undated revealed, Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident .to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality .Resident #1Record review of Resident #1's care plan revealed no mention of catheter care on foley catheter.During an interview on 06/30/2026 at 9:54 AM the Minimum Data Set (MDS) Nurse reviewed Resident #1's foley catheter care plan and confirmed that the care plan had not fully been developed to include providing catheter care. She stated that she doesn't normally put it on the care plan, just on the tasks for the aides. MDS nurse confirmed the purpose of the care plan was, To show a person how to take care of a person.Record review of the admission Record indicated Resident #1 was admitted to the facility on [DATE] with medical diagnoses that included Retention of Urine, unspecified; and Infection and Inflammatory reaction due to indwelling urethral catheter, subsequent encounter. Record review of the MDS, with an Assessment Reference Date (ARD) of 6/9/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 12, indicating Resident #1 had moderate cognitive impairment.Resident #15Record review of Resident #15's care plan for Diabetes Mellitus revealed, diabetic nail care to be done monthly and as needed (PRN) by Registered Nurse (RN).During observations and interviews with Resident #15 on 6/28/2026 at 2:51 PM and again on 6/29/2026 at 2:11 PM, his fingernails were observed to be approximately one (1) inch in length with jagged edges and a dark brown substance underneath. He stated the RN usually trims them every couple of weeks. He agreed they needed to be trimmed.During an interview on 06/30/2026 at 10:00 AM the MDS Nurse confirmed Resident #15's Diabetes care plan was not implemented by the facility staff to provide PRN nail care for Resident #15. The MDS nurse stated the purpose of a care plan was, To show a person how to take care of a person.Record review of the admission Record indicated Resident #15 was admitted to the facility on [DATE] with medical diagnoses that included Unspecified Psychosis not due to a substance or known physiological condition.Record review of the MDS, with an ARD of 4/21/2026, revealed under Section C a BIMS score of 15, indicating Resident #15 was cognitively intact.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, record reviews, and facility policy review, the facility failed to provide activities of daily living (ADL) care necessary to maintain personal hygiene for one (1) of 56 residents observed. (Resident #15) Findings include: Review of facility policy titled Activities of Daily Living undated revealed, .Care and services will be provided for the following activities of daily living: Bathing, dressing, grooming, and oral care .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 .Record review of Resident #15's Order Summary Report revealed an order dated 7/7/2024, Diabetic nail care to be done monthly and as needed (PRN) per Registered Nurse (RN).On 6/28/2026 at 2:51 PM and again on 6/29/2026 at 2:11 PM, during observations and interviews with Resident #15 his fingernails were observed to be approximately one (1) inch in length with jagged edges and a dark brown substance underneath. He stated the RN usually trims them every couple of weeks. He agreed they needed to be trimmed.During an interview on 6/29/2026 at 2:12 PM, the Director of Nursing (DON) confirmed Resident #15's fingernails needed to be trimmed. She stated diabetic nail care should be completed weekly by the RN. The DON confirmed that long jagged nails could cause a skin tear.Record review of the admission Record indicated Resident #15 was admitted to the facility on [DATE] with medical diagnoses that included Unspecified Psychosis not due to a substance or known physiological condition .Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/21/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #15 was cognitively intact.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to periodically reassess a resident's wheelchair alarm to determine whether it remained necessary and appropriate based on the resident's current assessed needs for one (1) of three (3) residents reviewed for falls. Resident #9 Findings Include: Review of the facility policy titled Accidents and Supervision revealed under, Policy: The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring for effectiveness and modifying interventions when necessary. Review of the facility policy titled Resident Alarms revealed under, Policy: It is the policy of this facility to utilize resident alarms in limited circumstances, in accordance with the resident's needs, goals, and preferences, so the resident will be able to attain or maintain his or her highest practical level of physical, mental, and psychosocial well-being. Additionally revealed under, Monitoring and modification: . c. Ongoing assessment of the resident shall occur to identify changes in patterns, routines, or medical symptoms of the resident. Interventions will be modified, as needed, to address any changes. d. Considerations for discontinuation of alarms include, but are not limited to: i. The medical symptoms or risks warranting the use of the alarms are no longer present. An observation of Resident #9 on 6/28/26 at 4:10 PM revealed she was sitting in her wheelchair in the front lobby with other residents watching television. A sensor alarm was attached to the back of the wheelchair. The resident stated she had no idea why she had the alarm. After inquiry about recent falls, she indicated she had not fallen in a long time and stated it had been years. Record review of Resident #9's Physician Order revealed an order dated 7/18/25, Ensure chair alarm is turned on and functioning properly. Record review of Resident #9's Incident Report dated 5/4/24 revealed, Patient in front lobby, up from wheelchair unassisted and attempting to ambulate by herself before falling on floor. No apparent injuries noted. An interview with the Director of Nursing (DON) on 6/29/26 at 2:00 PM revealed the resident had the chair alarm due to a history of falls. She confirmed the residents last fall was on 5/4/24. When inquired how the facility reassessed the continued need for the alarm, she replied, We assess it every time we have a care plan meeting, we talk about it. She confirmed there were no evaluations completed to ensure the ongoing need for the alarm. An interview with Licensed Practical Nurse (LPN) #2 on 6/30/26 at 8:20 AM revealed the resident did not try to get up from her wheelchair, had no recent falls, and the alarm was used as a preventative measure to prevent falls. Record review of Resident #9's Quarterly Fall Risk Evaluation dated 2/26/26 revealed the resident was chairbound and remained free from falls in the past 3 months. Record review of Resident #9's Quarterly Fall Risk Evaluation dated 5/19/26 revealed the resident was chairbound and remained free from falls in the past 3 months. Further review of both Quarterly Fall Risk Evaluations revealed there was no documented reassessment of the resident's continued need for the wheelchair alarm, evaluation of its effectiveness, consideration of less restrictive interventions, or trial reduction despite the resident remaining chair-bound and being free from falls since May 2024. An interview with the Minimum Data Set (MDS) Nurse on 6/30/26 at 9:30 AM revealed the facility tried to reduce alarm usage and, if a resident had not had a fall in a while, the alarms were removed. She stated there should be documentation supporting the ongoing need for Resident #9's alarm but she did not see any. She stated the resident had the alarm due to fall risk and, when inquired why a reduction had not been attempted since the resident had not fallen in two years, replied, I can't answer that. An interview with the DON on 6/30/26 at 11:08 AM (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed the resident could not walk and was unable to get up from the wheelchair without assistance. She stated the alarm was in place for fall prevention and confirmed the facility had not attempted a trial reduction of the alarm. Record review of the admission Record revealed the facility re-admitted Resident #9 on 7/26/24 with medical diagnoses that included Parkinson's Disease without Dyskinesia and Hemiplegia Unspecified Affecting left Nondominant Side. Record review of the MDS with an Assessment Reference Date (ARD) of 5/19/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #9 was cognitively intact. Additionally, revealed under section GG, the resident was dependent for sit to stand transfers.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, record review, and facility policy review, the facility failed to ensure staff used proper technique with catheter care to prevent a Urinary Tract Infection (UTI) for one (1) of two (2) residents with catheters. (Resident #1) Findings include: Review of facility policy titled Catheter Care, undated, revealed, Policy: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care. Compliance Guidelines. Assist resident to a lying position. Perform hand hygiene. [NAME] gloves. Using circular motion, cleanse the meatus with a clean cloth. With a new moistened cloth, starting at the urinary meatus moving down, cleanse the shaft of the penis. With a new moistened cloth, starting at the urinary meatus moving outward, wipe the catheter making sure to hold the catheter in place. During an observation of catheter care on 6/29/2026 at 3:33 PM, Certified Nursing Assistant (CNA) #1 used the same wipe throughout the entire catheter care procedure while cleansing the urinary meatus and catheter tubing. During an interview with CNA #1 following catheter care, she confirmed she should have used a new wipe with each step of cleaning the urinary meatus to help prevent the spread of infection, specifically to prevent a UTI. During an interview with the Infection Control Nurse, she confirmed CNA #1 should have used a new wipe with each step of cleaning the urinary meatus and catheter tubing. She stated failure to follow proper catheter care technique increased the resident's risk for infection, including UTIs. During an interview on 6/29/2026 at 3:55 PM, the Director of Nursing (DON) confirmed a new wipe should have been used for each step of cleaning the urinary meatus and catheter tubing during catheter care. Review of the admission Record indicated Resident #1 was admitted to the facility on [DATE] with medical diagnoses that included Retention of Urine, unspecified and Infection and Inflammatory reaction due to indwelling urethral catheter, subsequent encounter. Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/9/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 12, indicating Resident #1 had moderate cognitive impairment.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review the facility failed to ensure a self-administered medication was securely stored resulting in the medication being accessible to unauthorized individuals for 1 (one) of 56 residents reviewed. Resident #49 Findings Include: Review of the facility policy Medication Storage revealed, It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, light, ventilation, moisture control, segregation, and security . An observation on 06/28/26 at 3:03 PM revealed Resident #49 sitting on his bed with oxygen in use and there was an Albuterol Inhaler on top of his bedside table. He revealed that his lungs were bad and he's had to wear oxygen and use breathing treatments and inhalers for a long time. Resident #49 revealed that he kept the albuterol inhaler in his room and used it when he needed it. He also confirmed that he did not have a lock box in his room to keep the inhaler secured while not in use. An observation on 06/29/26 at 7:40 AM revealed Resident #49's Albuterol inhaler on top of his bedside table and he was not in his room at this time. An interview on 06/29/26 at 10:50 AM with Resident #49 revealed him lying in bed in his room. He revealed that he kept his inhaler in his pocket or on the bedside table and used it when he got short winded and stated, Some days I use it, some days I don't. Resident #49 revealed that he used it when he couldn't get to his nebulizer, like when he was in therapy or outside. Resident #49 confirmed that he had just returned from being outside and that he had left his inhaler in his room. He stated, I usually have it in my pocket when I leave my room in case I need it. On 06/29/26 at 1:25 PM, an interview with Licensed Practical Nurse (LPN) #1, revealed that Resident #49 was assessed and self-administered his inhaler as he needed it. She revealed that he either kept the inhaler on his bedside table or in his pocket. LPN #1 confirmed that medication should not be left in a room unattended and that by doing so, could result in other residents coming in and taking something they were not supposed to have. She revealed that they did have residents with dementia who wandered and this could cause problems if a resident took a medication that they were allergic to. On 06/29/26 at 1:40 PM, an interview with Director of Nursing (DON) revealed that Resident #49 was assessed to be competent with self-administration of his inhaler. She revealed that he had breathing problems and anxiety and on admission requested that he keep his inhaler. She revealed that the inhaler was normally on his person or on the bedside table within his sight for easy access when he needed a rescue breath. DON revealed that his inhaler should not have been left on bedside table in his room without him present and she would reiterate to him again. She confirmed that they had some residents who wandered in and out of rooms and stated that by leaving medications out and unsecured could result in residents taking something they were not supposed to have and agreed that this could result in adverse reactions. Record review of Resident #49's Order Summary Report revealed an order effective 05/19/26 for Albuterol Sulfate HFA (Hydrofluoroalkane) Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Micrograms/Actuation) (Albuterol Sulfate) 2 (two) puff inhale orally every 4 (four) hours as needed for SOB (Shortness of Breath)/WHEEZING related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED. Record review of Resident #49's Order Summary Report also revealed an order effective 05/22/26, RESIDENT MAY SELF ADMINISTER HIS ALBUTEROL HFA PRN (AS NEEDED) SOB/WHEEZING . Record review of Resident #49's admission (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record revealed that he admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease, Primary Pulmonary Hypertension, and anxiety disorder. Record review of Resident #49's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 05/25/26 under Section C, revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated that he had no cognitive deficits.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, record review, and facility policy review, the facility failed to ensure staff performed appropriate hand hygiene and changed gloves between a contaminated task and a clean resident care task to help prevent the spread of infection during one (1) of four (4) resident care observations (Resident #1). Findings include: Review of facility policy titled Standard Precautions Infection Control undated revealed, .During the delivery of resident care services, avoid unnecessary touching of surfaces in close proximity to the resident to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces .During an observation of catheter care on 6/29/2026 at 3:33 PM, Certified Nursing Assistant (CNA) #1 assisted Resident #1 with removal of his clothing and undergarment. CNA #1 then proceeded to provide catheter care while wearing the same gloves used during the clothing removal and did not perform hand hygiene before initiating catheter care. During an interview with CNA #1 following catheter care, she confirmed hand hygiene should have been performed before providing catheter care to help prevent the spread of infection, specifically urinary tract infections (UTIs). During an interview with the Infection Control Nurse on 6/29/2026 at 3:50 PM, she confirmed CNA #1 should have performed hand hygiene before proceeding with catheter care. She stated that failure to perform hand hygiene during catheter care increased the resident's risk for infection, including UTIs. She further stated she had recently educated staff regarding peri care and hand hygiene. During an interview on 6/29/2026 at 3:55 PM, the Director of Nursing (DON) confirmed hand hygiene should have been performed after assisting Resident #1 with clothing removal and before initiating catheter care to help prevent the spread of infection. Review of the admission Record indicated Resident #1 was admitted to the facility on [DATE] with medical diagnoses that included Retention of Urine, unspecified; and Infection and Inflammatory reaction due to indwelling urethral catheter, subsequent encounter. Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/9/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 12, indicating Resident #1 had moderate cognitive impairment.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy review, the facility failed to ensure pneumococcal immunizations were administered in accordance with physician oversight, facility policy, and current CDC recommendations for one (1) of five (5) residents reviewed for immunizations (Resident #42). Specifically, after the resident representative consented to pneumococcal vaccination, the facility failed to notify the physician when the electronic medical record generated a contraindication alert related to long-term steroid therapy. Instead, the vaccine was incorrectly documented as refused without physician evaluation to determine whether administration was appropriate. This deficient practice resulted in Resident #42, who had pulmonary fibrosis and was receiving long-term systemic corticosteroid therapy, not receiving a recommended pneumococcal vaccine despite having conditions that increased the resident's risk for pneumococcal disease. Findings Include: Record review of the facility policy titled Pneumonia Vaccine (Series) revealed under, Policy: It is our policy to offer residents and staff immunizations against pneumococcal disease in accordance with current CDC (Centers for Disease Control and Prevention) guidelines and recommendations. Additionally revealed under, Policy Explanation and Compliance Guidelines: . 7. A pneumococcal vaccination is recommended for adults who have certain chronic medical conditions or other risk factors which may include: . e. Chronic lung disease . o. Iatrogenic immunosuppression, including long-term systemic corticosteroids .Record review of Resident #42's Immunization Record revealed she did not receive the pneumonia vaccine due to refusal. Record review of the Pneumococcal Vaccine Consent dated 4/3/26 revealed the resident representative (RR) signed the consent for administration of the vaccine. Further review revealed documentation by the Infection Preventionist (IP), RP (responsible party) notified that resident is unable to receive this vaccine d/t (due to) prolong use of steroid use. Contraindicated. An interview with the IP on 6/30/26 at 9:11 AM revealed the RR for Resident #42 consented to the pneumonia vaccine. The IP explained that when she entered the vaccine into the facility's charting system to be administered, the system generated an alert indicating the vaccine was contraindicated because the resident was taking steroids. She confirmed she did not reach out to the physician to ensure the vaccine was safe to administer and called the RR to notify them it was contraindicated, documenting the vaccine as refused. She acknowledged that a resident taking steroids was at an increased risk for infections. The IP further revealed the resident also had pulmonary fibrosis, which made her more susceptible to respiratory infections. An interview with the Director of Nursing on 6/30/26 at 11:04 AM revealed the IP should have notified the physician if she received a contraindication alert on the pneumonia vaccine. The DON further stated it was important for a resident taking steroids to receive a pneumonia vaccine since they were at increased risk for infections. Record review of the admission Record revealed Resident #42 was admitted on [DATE] with medical diagnoses that included Unspecified Dementia and Pulmonary Fibrosis. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/12/26 revealed, under Section C, a Brief Interview for Mental Status (BIMS) score of 7, indicating Resident #42 was severely cognitively impaired.		