

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255106	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/12/2024
NAME OF PROVIDER OR SUPPLIER BRANDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 355 CROSSGATE BLVD BRANDON, MS 39042		
(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 Complaint Investigations (CIs), MS #25033 , CI MS #25409, and CI MS #25439 at the facility from 6/11/24 through 6/12/24. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. CI MS #25033 was investigated related to resident neglect concerning pressure ulcers, quality of care/treatment concerning call bells not answered in a timely manner, resident left soiled for extended periods, and physical environment and F584 was cited. CI MS #25409 was investigated related to resident neglect and quality of care/treatment concerning staffing. CI MS #25439 was investigated related to discharge planning. There were no citations related to CI MS #25409 or CI MS #25439.	F 000			
F 584 SS=E	The facility held a license for 230 beds, with a census of 228. Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident	F 584			7/25/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/03/2024

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255106	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/12/2024
NAME OF PROVIDER OR SUPPLIER BRANDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 355 CROSSGATE BLVD BRANDON, MS 39042		
(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 584	Continued From page 1 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and facility policy review, the facility failed to ensure a safe, clean homelike environment for two (2) of six (6) residents' rooms (Resident #3 and Resident #4), one (1) of three (3) shower rooms, and one (1) of three (3) hallways observed. Findings include: Review of the facility's policy "Resident Room Cleaning" with History Date 6/18 (June 2018) revealed, "Responsibility: Housekeeping Staff.	F 584	1. Resident #3 and #4 rooms, resident shower rooms, and hallways were cleaned by the Housekeeping Supervisor on June 11, 2024. On June 12, 2024 Resident #4 mattress was replaced. No resident had any ill effects from this alleged deficient practice. 2. All Residents have the potential to be affected by this alleged deficient practice.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255106	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/12/2024
NAME OF PROVIDER OR SUPPLIER BRANDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 355 CROSSGATE BLVD BRANDON, MS 39042		
(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 584	Continued From page 2 Procedure ...6. Use ...disinfectant on room surfaces ...10. Clean window glass. 11. Spot clean walls/damp wipe vertical surfaces/counters/ledges/sills ...16. Dust mop and damp mop floor ..." Review of the facility's policy, "Shower Room Cleaning" with History Date 6/18 (June 2018) revealed, "Responsibility: Housekeeping Staff. Procedure ...5. Disinfect vertical and horizontal surfaces. 6. Damp mop floor with disinfectant ..." Resident #3 On 6/11/24 at 3:00 PM, observation and an interview with Resident #3 in in the resident's room revealed that the floor was dirty with several various items of trash and many stains on the floor. The windows were difficult to see through and appeared hazy; the windows were rough and dusty to touch. Dust was easily wiped from the windows with a paper towel and tap water; the area wiped with the wet paper towel was noticeably easier to see through in contrast to the rest of the windows. The windowsills of all three large windows which spanned one wall of the room were littered with trash and a black substance that wiped off easily with a wet paper towel. The floor beneath the bed and nightstand of Resident #3 was littered with bits of unrecognizable irregularly shaped bits of trash that ranged from dime sized to half dollar sized and dust that wiped from the floor easily with a wet paper towel. There was a pair of Resident #3's shoes under the air conditioner unit on the right side of the room beneath the window that were covered with dust. Resident #3 stated he did not know how long the shoes had been there and he confirmed that the shoes would need cleaning	F 584	3. An in-service was initiated on June 12, 2024 by the Executive Director for the Housekeeping Supervisor on ensuring residents have a safe, clean, homelike environment. An in-service was initiated on June 12, 2024 by the Executive Director for the housekeeping on ensuring residents have a safe, clean, homelike Environment. An in-service was initiated on June 12, 2024 by the Executive Director for Department Heads on ensuring residents have a safe, clean, homelike environment. An in-service was initiated for staff on June 12, 2024 on ensuring residents have a safe, clean, homelike environment. A 100% audit was completed on July 2, 2024 on ensuring residents have a safe, clean, homelike environment. 4.The Executive Director and/or Assistant Executive Directors will make rounds on resident rooms, resident shower rooms and hallways 3x week x 4 weeks then weekly x 2 week beginning June 17, 2024 to ensure residents have a safe, clean, homelike environment. The Executive Director and/or Assistant Executive Directors will address any concerns immediately. The Quality Assurance Committee met on June 28, 2024. The next Quality Assurance meeting will be held on July 24, 2024. The Quality Assurance Committee will make recommendations to extend the audits.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255106	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/12/2024
NAME OF PROVIDER OR SUPPLIER BRANDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 355 CROSSGATE BLVD BRANDON, MS 39042		
(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 584	Continued From page 3 before he wore them due to a layer of dust on both shoes. There was a dark gray/black substance on the floor around the edge of the walls and in the corners at the entrance of the room along the walls of the bathroom and closet that wiped off easily with a wet paper towel. Resident #3 voiced disappointment in the quality of housekeeping services. He stated that he would prefer his room to be cleaner. The resident stated, "They could definitely do better with housekeeping. Look at that floor. I can't do it." On 6/11/24 at 4:33 PM, an interview with the Housekeeping Supervisor confirmed she had just been hired in the position and had two new housekeepers in orientation on 6/11/24. She confirmed that each resident's room was supposed to be dusted and swept and the floor cleaned daily. She stated that the windows and windowsills should be checked and cleaned daily or as needed. Regarding the windows and windowsills, she stated, "they need to be cleaned". She confirmed that she could easily notice the difference in the window where the window had been wiped with wet paper towel. She stated she had not noticed the dust that covered the decorative items in the hallway outside Resident #3's room, but that they needed to be cleaned. She said she had noticed the hand sanitizer dispensers being "dirty" and that she had not had a chance to clean them but had already planned to address the cleaning of the dispensers. On 6/12/24 at 2:38 PM, during a telephone interview with a family member of Resident #3, they voiced concern related to the housekeeping services and the lack of cleanliness of the resident's room. They stated they visited every	F 584			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255106	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/12/2024
NAME OF PROVIDER OR SUPPLIER BRANDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 355 CROSSGATE BLVD BRANDON, MS 39042		
(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 584	Continued From page 4 week, and the floor was always "messy and dirty" and that the surfaces in the room were always dusty. Record review of the "Face Sheet" for Resident #3, revealed the facility admitted the resident on 11/10/23 and the resident had diagnoses including Depression. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/06/24 for Resident #3 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated no cognitive impairment. Resident #4 Record review of the "Face Sheet" for Resident #4, revealed the facility admitted the resident on 1/25/19 and the resident had diagnoses including Unspecified urinary incontinence. Record review of the Quarterly MDS with and ARD of 3/25/24 for Resident #4 revealed the resident had a BIMS score of 15, which indicated no cognitive impairment. On 6/11/24 at 2:00 PM, observation and an interview with Resident #4 revealed a strong urine odor in the hallway outside the resident's room. The odor was stronger in the resident's room. Resident #4 was resting in bed with the top sheet and blanket bundled in her arms. Resident #4 reported that she had an episode of bladder incontinence and was waiting for the Certified Nursing Assistant (CNA) to come change her and was trying to keep the flat sheet and blanket from getting wet.	F 584			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255106	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/12/2024
NAME OF PROVIDER OR SUPPLIER BRANDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 355 CROSSGATE BLVD BRANDON, MS 39042		
(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 584	Continued From page 5 On 6/11/24 at 2:15 PM, an interview with CNA #1 revealed she was the CNA assigned to provide care for Resident #4 on 6/11/24. She confirmed that the room held the odor of urine which was notable in the hallway outside the resident's room. On 6/11/24 at 2:22 PM, observation and an interview with Registered Nurse (RN) #1 she confirmed that there was a strong urine odor inside and outside Resident #4's room. On 6/12/24 at 3:10 PM, observation and an interview with the Administrator he confirmed that there a strong urine odor inside and outside Resident #4's room. The Administrator stated that it was possible that the resident's mattress needed to be cleaned or replaced. Shower Room On 6/12/24 at 11:42 AM, observation and an interview with the Housekeeper on the back hall revealed the floor of the back hall shower room between the toilet and the door had six (6) scattered quarter to half dollar brown stains which wiped off readily with a wet paper towel. The Housekeeper reported that she was assigned to provide cleaning of the shower room which included the floor on 6/11/24 and 6/12/24. She stated she had not cleaned the floor of the shower room on 6/11/24 or 6/12/24. She confirmed that the shower room floor was dirty but said she did not know what the substance on the floor was. She stated that barriers to cleaning the shower room included being assigned to approximately thirty (30) resident rooms and not being able to clean the shower room during	F 584			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255106	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/12/2024
NAME OF PROVIDER OR SUPPLIER BRANDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 355 CROSSGATE BLVD BRANDON, MS 39042		
(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 584	Continued From page 6 resident care (showers) or during mealtimes. She reported that no one had reported to her that the floor was dirty or in need of housekeeping attention. Hallway Observation revealed that on the wall in the hallway outside Room 214 there was a two foot by two-foot (2' X 2') decorative wall art and a two-foot (2') wall mounted metal half vase filled with silk greenery. Both decorative pieces were covered by brownish gray dust as thick as two stacked quarters (approximately 3.5 millimeters) that were easily wiped/plucked in clumps from the items. There were nine (9) wall mounted hand sanitizer dispensers in the hallway outside the resident's room placed on both sides of the hallway between the nurse's station and the exit door. The tops of all dispensers were coated with gray substance and the floor and wall protector shields of each were discolored with a brownish gray substance not easily wiped away. On 6/12/24 at 3:00 PM an interview with the Administrator revealed he expected each resident and all common areas be provided with housekeeping services daily and as needed to provide a clean environment free of malodorous smells and that the facility housekeeping policies to be followed. He stated that there had been challenges with securing housekeeping staff and that it was an ongoing process of hiring, training and retaining housekeeping staff.	F 584			