STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255106	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON NURSING AND REHABILITATION CENTER	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 six (6) Complaint Investigations (CI MS #27305, CI MS #27400, CI MS #27401, CI MS #27428, CI MS #27463, and CI MS #27815), at the facility from 1/28/25 through 1/31/25. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. CI MS #27305 was investigated for residents not groomed, roaches in facility, facility no clean, and offensive odors in the facility and F584 was cited. CI MS #27400 was investigated for admission, transfer, and discharge rights, quality of care/treatment, and refusal to re-admit and there were no deficiencies cited related to that investigation. CI MS #27401 was investigated for staffing, resident safety, and facility not clean and F584 and F725 were cited. CI MS #27428 was investigated for neglect, resident left wet and soiled for extended periods, pressure sores, and responsible party not notified and F690 was cited. CI MS #27463 was investigated for no hot water, cold food, resident left soiled, staffing, medications, roaches in facility, and inappropriate feeding assistance and F584 and F693 were cited. CI MS #27815 was investigated for resident left wet and roaches in facility and F584 and F690 were cited. The facility held a license for 240 beds, with a census of 219 residents.	F 000		
F 584 SS=E	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	F 584		3/5/25

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

Electronically Signed | 02/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255106	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON NURSING AND REHABILITATION CENTER	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 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 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 observations, interviews, facility policy review and record review the facility failed to	F 584	1. Resident #7□s room O2 concentrator was cleaned of dried tan colored brown	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255106	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON NURSING AND REHABILITATION CENTER	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 provide a safe, functional, sanitary environment for three (3) of four (4) days of survey that affected Residents #2, #4, #7 and #8. Finding included: Record review of the facility policy titled "HOUSEKEEPING CLEANING PROCEDURES" dated 6/18 revealed "RESPONSIBILITY: Housekeeping Staff. PROCEDURE: ...4. Survey room/remove used items/trash ...11. Spot clean walls/damp wipe vertical surfaces ...Dust mop and damp mop floor ...Weekly Procedure ...4. Wipe walls...". Record review of a typed statement on facility letterhead and signed by the Administrator, undated, revealed "(Proper name of facility) does not have a pest control policy. We have a Bill of Rights for a clean environment.". Record review of the "RESIDENT BILL OF RIGHTS" with a history of 1/23 revealed "Facility residents shall have the right to...32. A safe clean, comfortable home like environment..." Resident #7 On 1/28/25 at 3:10 PM, observation revealed Resident #7 was resting quietly in her bed in her room with enteral feeding solution suspended from an infusion pole. She had oxygen via concentrator at 2 liters per minute via nasal cannula. The oxygen concentrator had scattered dried tan colored/ brown spots of a glossy, dried substance covering the top and front. The four bases of the infusion pole had egg shaped areas of dried tan colored/ brown spots of a glossy, dried substance. The base of the resident's over	F 584	spots by the charge nurse on January 28, 2025. Resident #7□s bedside table was cleaned of tan colored spots by the Maintenance Director on January 28, 2025. The four bases of the infusion pole were cleaned by the Maintenance Director on January 28, 2025. Resident #7□s room was deep cleaned by the Housekeeping Supervisor on January 28, 2025. Resident #7□s Unit staff was in serviced by the Staff Development nurse on cleaning resident□s oxygen concentrator, infusion pole and bedside tables. Resident #7 was assessed by the Unit Manager on January 28, 2025. There were no ill effects noted. Resident #8□s room was deep cleaned by the Housekeeping Supervisor on January 28, 2025. Resident #8□s bathroom was deep cleaned by the Housekeeping Supervisor on January 28, 2025. The Housekeeping supervisor was in serviced by the Staff Development nurse on January 28, 2025. Resident #8□s room was sprayed for pest control by the Maintenance Director on January 28, 2025. Resident #8 was assessed by the Unit Manager on January 28, 2025. There were no ill effects noted. Resident #2□s room was deep cleaned by the Housekeeping Supervisor on January 29, 2025. Resident #2□s room was painted by the Maintenance Director on January 29, 2025. There were no ill effects noted. Resident #4□s room was deep cleaned	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255106	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON NURSING AND REHABILITATION CENTER	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 the bed table was covered with pea sized spots dried tan colored/ brown spots of a glossy, dried substance. On 1/28/25 at 3:15 PM, observation revealed the floor of the Day Room on Unit 4 was cluttered with trash which included food, cellophane wrapping, a white plastic fork and other unrecognizable debris. There was one resident who was sitting in a wheelchair in the room at the time. Resident #8 On 1/28/25 at 5:40 PM, observation of Resident #8's room accompanied by Certified Nursing Assistant (CNA) #5 revealed the floor had brown and gray streaks and was littered with paper in the form of candy wrappers, red crayon wrap paper, a meal tray slip, two white napkins, an opaque cup lid, a black plastic tag, a nugget sized piece of dried grilled cheese, and an upside down opaque plastic cup. There were twenty-five (25) golden yellow to tan the approximate size of pencil erasers under the privacy curtain between the resident's side of the room and his roommate's and under the resident's infusion pole holding his enteral feeding bottle and pump. There was a dried black item the size of a large bean balanced on the edge of the top of Resident #8's headboard. The base of the bed of Resident #8, the window blinds, the top and front of the air conditioner was covered by a layer of a dry, dusty, gray substance. The metal base of the resident's over the bed table was covered by pin prick to rice grain sized dry, brick red colored spots of abrasive texture. The beige privacy curtain in Resident #8's room had four palm sized brown spots midway up the length of the cloth.	F 584	by the Housekeeping Supervisor on January 30, 2025. Unit four□s day room was deep cleaned by the Housekeeping Supervisor on January 30, 2025. Resident #4□s dresser was replaced by the Maintenance Director on January 30, 2025. There were no ill effects noted. 2. Any resident has the potential to be affected by this alleged deficient practice. 3. On January 30, 2025, all staff in service was initiated on keeping a safe/clean/environment including resident rooms by the Staff Development Nurse. The in services on keeping a safe/clean/environment including resident rooms will be completed by March 3, 2025. 4. On February 17, 2025, the Executive Director and/or Assistant Executive Director initiated resident room audits of ten resident rooms weekly for six weeks on each unit, then five resident rooms weekly for six weeks on each unit. Any issues noted will be immediately addressed. The Executive Director will forward the results to the Quality Assurance Committee meeting. Starting February 26, 2025, the results will be reviewed monthly times three months. The Quality Assurance Committee meeting will make recommendations based on the findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255106	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON NURSING AND REHABILITATION CENTER	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	F 584		

There were golden brown to black streaks and spots on the closet doors and drawer fronts of the attached chest of drawers. There was an empty trash can and a full bag of trash on the floor in the resident's bathroom. There were two quarter inch brown bugs crawling on the floor under the resident's bed and one crawling up the wall behind the head of the resident's bed.

On 1/28/25 at 6:35 PM, an interview with the Assistant Administrator and the DON, the Assistant Administrator stated that the floor of Resident #8's room "needs cleaning and mopping". She confirmed that the floor was littered with trash and food. She said she did not know what the black item balanced on the resident's headboard was and said, "I don't know what that is, don't touch it". She stated that scuffs, scratches and areas of missing paint were "probably wear and tear from wheelchairs". She said the floor, closet doors and chest drawer fronts looked "dirty, like something dripped on it". She stated that Resident #8's bed frame "could use a cleaning" and described it as "stained and dirty". She confirmed that she observed a roach on the floor and a roach on the wall next to and behind the resident's bed. She stated that the bed table needed to be cleaned or replaced. She confirmed that there was one roach crawling on the floor next to the resident's bed and one on the wall behind the head of his bed.

On 1/28/25 at 7:06 PM, an interview with the Maintenance Director revealed that tops on the air conditioner units in residents' rooms should be dusted or wiped off by housekeepers daily and the filters were to be cleaned by the maintenance staff at least monthly. He said he did not keep a log of air conditioner maintenance or filter

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255106	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON NURSING AND REHABILITATION CENTER	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	F 584		

cleaning.

Resident #2

On 1/29/25 at 11:35 PM, observation revealed Resident #2's room, there were forty-three (43) spots of a dried, glossy, golden brown, approximately the diameter of a grain of sugar, two spots the size of pencil erasers and one pea sized spot and one the size of a large lima bean on the top of the air conditioner below the window of Resident #2's air conditioner.

Resident #4

On 1/30/25 at 3:20 PM, during an observation Resident #4's room revealed the floor was littered with tissue paper, candy wrappers, bits of tin foil, a writing pen, candy and cereal. There was one wheelchair footrest under the resident's bed. The wall under the window was spotted with pencil eraser sized spots of a dried, glossy, golden-brown substance. The baseboard around the walls of the room was stained with tan, brown and black streaks and spots. The floor in the corners of the room were covered in a sticky black substance. There were two chests of drawers in the room, one with empty pencil eraser sized holes in the four (4) drawers with no handles or pulls and the other with four (4) drawers that were crooked and lopsided. The drawers were streaked with tan and brown streaks.

On 1/31/25 at 10:13 AM, an interview with the Housekeeping Director revealed that each resident's room should be dusted, swept, and damp mopped each day, and the attached bathrooms cleaned, and the trash containers

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255106	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON NURSING AND REHABILITATION CENTER	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	F 584		

emptied with liners replaced in the rooms and bathrooms. She stated that if there were stained walls or walls with missing paint, rusted over the bed tables or other issues involving cleanliness in the rooms outside of the scope of the housekeeping staff, she had instructed the housekeepers to notify her and she would notify the Maintenance Director. She said that housekeepers should assess bed frames for dust and provide cleaning as needed. She stated that no one had reported pests in resident rooms to her. She said that pests were supposed to be reported to the Maintenance Director or Administrator because they tended to the pest control contracts/notified contractors if needed. She stated that staffing had been a challenge. She stated that the facility had two (2) full-time housekeepers and (1) part-time housekeepers and six (6) floor technicians. She stated that the floor technicians were "pulled" to assist with housekeeping duties. She stated that the facility had four (4) full time laundry aids who worked 6:00 AM through 10:00 PM and delivered clean linens to the clean linen closets every two (2) hours. She confirmed that on 1/31/25 two CNAs were pulled from direct patient care to work in laundry from 8:00 AM to 12:00 PM. She stated she scheduled housekeeping daily which included assignment of rooms. She said that two (2) to three (3) rooms were scheduled for deep cleaning everyday Monday through Friday each week. She confirmed that the facility housed residents in approximately one hundred and twenty-nine (129) rooms with attached bathrooms based on census and there were several common rooms and areas including three (3) day/dining/activity rooms and eight common shower rooms in the facility. She confirmed that dining rooms should be policed by housekeepers

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255106	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON NURSING AND REHABILITATION CENTER	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 7 and trash/litter/food cleaned from dining areas following meals. On 1/31/25 at 5:13 PM, an interview with the Administrator revealed that due to the conditions in the facility he had hired a new Housekeeping Director and six (6) new housekeepers which had not started employment yet. He stated that he expected the housekeeping staff to keep the residents' rooms and common areas such as day and dining rooms clean, sanitary and free from clutter and litter. He stated that any staff could wipe up spills or report maintenance issues such as rusty or broken furniture which should be cleaned, repaired or replaced.	F 584		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition	F 690		3/5/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255106	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON NURSING AND REHABILITATION CENTER	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 690	Continued From page 8 demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review and facility policy review, the facility failed to ensure that a resident that required assistance with toilet use and toilet hygiene received care in a routine or timely manner for one (1) of eight (8) sampled residents, Resident #6. Findings include: A review of the facility's policy, "Incontinent Care" dated 1/2015 revealed, "Policy: To provide routine, preventive skin, perineal care to residents after an incontinence episode. RESPONSIBILITY: All Nursing Personnel.". On 1/28/25 at 1:15 PM, during a telephone interview the Resident Representative (RR) for Resident #6 stated that she had visited the facility several times and observed the resident with wet incontinence briefs and that on 12/23/24 she visited, discovered the resident was wet and observed incontinence care. The resident's brief was saturated, and her clothes were wet and	F 690	1. Resident #6 immediately was assessed for activities of daily living assistance by the certified nurse assistant (cna) on January 28, 2025. Resident #6 had no ill effects noted. The certified nurse assistant (cna) was in serviced by the Staff Development nurse on January 28, 2025 on ensuring residents receive activities of daily living assistance in a timely manner. 2. Any resident that requires assistance with activities of daily living has the potential to be affected by this alleged deficient practice. 3. On January 28, 2025, an in serviced was initiated for all nursing staff by the Staff Development nurse on ensuring residents receive activities of daily living care in a timely manner. The in services	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255106	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON NURSING AND REHABILITATION CENTER	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 690	Continued From page 9 smelled of urine. On 1/28/25 at 3:02 PM, observation revealed Resident #6 sitting in a wheelchair in the hallway across from the Unit 3 nurses station. The resident was propelled by Staff #1 to the Bingo activity in the dining/activity room without being taken to her room. On 1/28/25 at 4:03 PM, during an interview Certified Nurses' Aide (CNA) #1 stated that she had been at work since approximately 7:00 AM and was assigned to rooms 300 through 304, 319 and 321. She said that CNA #3 had left for the day at approximately 1:30 PM, immediately after lunch trays were retrieved from residents' rooms following lunch. She said that lunch trays arrived at the unit at approximately 12:30 PM and all CNAs served lunch and assisted residents with eating as needed. She said that it was her understanding, based on a verbal report received from CNA #3 that she had not made rounds or checked any incontinent residents after lunch trays arrived on the unit. CNA #1 stated that she had not checked Resident #6 for incontinence needs or provided any care for her since assuming the care of CNA's assigned group of residents at 1:30 PM. She confirmed that based on her account of events the last time Resident #6 could have been checked or provided any care for toilet use or toilet hygiene would have been prior to 12:30 PM. CNA #1 confirmed that Resident #6 did not receive monitoring for incontinence or incontinence care from approximately 12:30 PM until approximately 4:00 PM. CNA #1 stated that every incontinent resident that required assistance for toilet use/hygiene was supposed to be checked at least every two (2) hours, as needed and upon request	F 690	on ensuring residents receive activities of daily living care in a timely manner will be completed by March 3, 2025. 4. On February 17, 2025, the Director of Nursing initiated resident incontinent care audits of ten resident weekly for six weeks on each unit, then five residents weekly on each unit for six weeks. Any issues noted will be immediately addressed. The Director of Nursing will forward the results to the Quality Assurance Committee meeting. Starting February 26, 2025, the results will be reviewed monthly times three months. The Quality Assurance Committee meeting will make recommendations based on the findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255106	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON NURSING AND REHABILITATION CENTER	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 690	Continued From page 10	F 690		

with assistance provided as needed.

On 1/28/25 at 4:06 PM during an interview CNA #2 explained she was assigned to the care of Resident #6 for 3:00 PM through 11:00 PM and that at approximately 4:00 PM while she was making rounds, she checked the resident who was wearing a wet incontinence brief and had provided incontinence care at that time. She said she was not aware of the last time the resident received care.

On 1/28/25 at 4:15 PM an interview with Licensed Practical Nurse (LPN) #8 revealed she confirmed that CNA #3 had been assigned to the routine monitoring/care for Resident #6 beginning at approximately 7:00 AM and had left at approximately 1:30 PM, immediately after picking up lunch trays. She confirmed that the LPNs and Unit Manager supervised the provision of care for residents and said she was not aware of the resident being taken to her room between 1:30 PM and approximately 4:00 PM for incontinence care.

On 1/31/25 at 5:00 PM, an interview with the Director of Nurses (DON) revealed she expected all residents with incontinence who required assistance with toilet use/hygiene to be checked at least every two hours, as needed, and upon request and care provided as soon as possible. She confirmed that three and a half (3 ½) hours was too long for a resident to wait between monitoring for incontinence. She confirmed that repeated episodes of staff not working scheduled hours could affect resident care.

On 10/31/25 at 5:13 PM, an interview with the Administrator confirmed that all residents who

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255106	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON NURSING AND REHABILITATION CENTER	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 690	Continued From page 11 required assistance with toilet use/hygiene to be checked at least every two hours, as needed, and upon request and care provided as soon as possible. He confirmed that three and a half (3 ½) hours was too long for a resident to wait between monitoring for incontinence. Record review of the Admission Record for Resident #6, revealed the facility admitted the resident on 1/05/16 and the resident had diagnoses of Dementia. Record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/12/24 revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. Further MDS review revealed the resident was assessed by the facility as "Always Incontinent" of bowel and bladder, was dependent on staff for toilet use and required maximum assistance for toilet hygiene.	F 690		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the	F 693		3/5/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255106	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON NURSING AND REHABILITATION CENTER	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 693	Continued From page 12 resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to provide care/services to a resident who had a feeding tube according to the resident needs and consistent with practitioner's orders for one (1) of two (2) sampled residents reliant on feeding tubes for nutrition. Resident #7 Findings included: Record review of the facility polity titled "Enteral Nutrition" dated 2017 revealed " ...1.a.The choice of the enteral feeding depends on the medical and nutritional needs of the individual as assessed by the Registered Dietitian and physician ...General Principals & Guidelines: 3.a.Continuous Drip ...The TF (Tube Feeding) is usually infused for a total of 18 to 24 hours and should be individualized allowing for potential down time for personal care or rehab therapy sessions ....". Record review of the "Order Summary Report" with active orders as of 1/28/2025 for Resident #7 revealed a physician order dated 9/11/2024 "Enteral Feed Order every night shift Enteral: Closed system container-Change feeding administration set with each new bottle; label the	F 693	1. On January 28, 2025, resident #7's charge nurse was in serviced on the importance of following the physician's orders regarding residents who require enteral feeding nutrients. On January 28, 2025, the Unit Manager assessed resident #7. There were no ill effects noted 2. Any resident that require enteral feeding nutrients have the potential to be affected by this alleged deficient practice. 3. On January 28, 2025, an in-service was initiated for all nursing staff by the Staff Development nurse on the importance of following the physician's orders regarding residents who require enteral feeding nutrients. The in services on the importance of following the physician's orders regarding residents who require enteral feeding nutrients will be completed by March 3, 2025. On January 28, 2025, a 100% audit was initiated on residents who require enteral feeding nutrients by the Unit Manages. 4. On February 17, 2025, The Director of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255106	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON NURSING AND REHABILITATION CENTER	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 693	Continued From page 13 formula container, syringe and administration set with resident's name, date, time and nurse's initials. An additional order dated 2/26/2024 revealed "GLUCERNA 1.5 at 50 ML/HR (milliliters per hour) CONTINUOUS FEED three times a day related to Gastrostomy status." An order dated 11/22/2024 revealed "HOLD ENTERAL FEEDING 30 MINUTES PRIOR TO MEALS before meals for HOLD FEEDING." On 1/28/25 at 3:10 PM, an observation revealed Resident #7 was resting quietly in her bed in her room with Glucerna with Carbohydrates 1.5 Cal dated 1/27/25, (no time or nurse's initials documented) suspended from an infusion pole. The enteral feeding pump was turned off and the tube feeding formula was not infusing. Calibration on enteral feeding bottle measured 625 cubic centimeters (cc). On 1/28/25 at 5:30 PM, an observation revealed Resident #7's enteral feeding pump was off. Calibration on enteral feeding bottle measured 625 cc. On 1/28/25 at 6:10 PM, an observation revealed Resident #7's enteral feeding pump was off. Calibration on enteral feeding bottle measured 625 cc. On 1/28/25 at 7:04 PM, an observation revealed Resident #7's enteral feeding pump was off. Calibration on enteral feeding bottle measured 625 cc. On 1/28/25 at 7:15 PM, during an interview with Licensed Practical Nurse (LPN) #6 and the Director of Nursing (DON), LPN #6 confirmed that the enteral feeding for Resident #7 had been	F 693	Nursing initiated an audit of five residents per unit who require enteral nutrients, five days weekly for six weeks, then three days weekly for six weeks. Any issues noted will be immediately addressed. The Director of Nursing will forward the results to the Quality Assurance Committee meeting. Starting February 26, 2025, the resultswill be reviewed monthly times three months. The Quality Assurance Committee meeting will make recommendations based on the findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255106	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON NURSING AND REHABILITATION CENTER	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 693	Continued From page 14 turned off since 3:00 PM. She expressed confusion regarding physician orders for the resident's enteral feeding, finally stated that the feeding was supposed to be turned off for an hour prior to delivery of the resident's pleasure tray at supper time. She stated that it was difficult to gauge when to turn it off because supper trays were not delivered at consistent times each evening. She confirmed that supper trays were not delivered at 4:00 PM, and said it was usually closer to 5:00 PM. The DON stated that the resident's enteral feeding should have been "turned off" for no longer than thirty (30) minutes and that feeding being held for over four (4) hours could have affected the resident's daily nutritional and hydration needs. On 1/31/25 at 5:13 PM an interview with the Administrator revealed that he expected physician orders and facility policies for residents who relied on enteral feeding for nutrition to be followed. On 1/31/25 at 7:00 PM an interview with the Primary Healthcare Provider for Resident #7 and facility Medical Director confirmed that the enteral feeding was to be held for thirty (30) minutes prior to the staff serving the resident a pleasure tray for supper. Record review of the Admission Record for Resident #7, revealed the facility admitted the resident on 2/07/24 and the resident had diagnoses of Aphasia, Gastrostomy status, Diabetes, and Metabolic Encephalopathy.	F 693		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)	F 725		3/5/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255106	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON NURSING AND REHABILITATION CENTER	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 725	Continued From page 15 §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, the facility failed to ensure sufficient nursing staff to meet the needs of residents for eight (8) of 16 staffing days reviewed in December 2024, (12/16/24, 12/23/24, 12/24/24, 12/25/24, 12/26/24, 12/27/24, 12/28/24 and 12/31/24). Findings Include:	F 725	1. On February 3, 2025, the Executive Director reviewed the facility assessment tool to ensure that staffing levels meet the assessment needs of the residents. 2. All residents who require assistance from staff have the potential to be affected by this alleged deficient practice. 3. On February 14, 2025, the Executive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255106	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON NURSING AND REHABILITATION CENTER	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 725	Continued From page 16 On 12/21/24 an anonymous complaint revealed a lack of housekeeping staff and inadequate direct care staff to provide adequate care for residents. On 1/28/25 at 4:03 PM, interview with Certified Nursing Assistant (CNA) #1 revealed CNA #3 left at approximately 1:30 PM. Her group of residents was added to CNA #1. CNA #1 stated that she had not had time to provide incontinence monitoring or care for Resident #6 between approximately 1:30 PM and 3:00 PM. On 1/28/25 at 5:00 PM, based on a confidential interview and confirmed by record review, staff reports for their shifts, sometimes up to an hour and a half after they are scheduled to arrive. The interviewee stated that sometimes the staff being relieved would stay and sometimes they left the facility. The interviewee stated that they recently (unable to recall date) reported for duty and discovered no CNAs on Unit 3. The interviewee said they contacted the Staff Development Director and was told that she was working on it. They said they then contacted the Administrator and was told to do the best possible. The interviewee stated that when there was not adequate staff on the 7:00 AM to 3:00 PM shift staff did the best they could, which included not getting residents out of bed or provision of showers per resident preferences. On 1/30/25 at 1:20 PM, during a telephone interview Resident #1 stated that on 12/07/24, her second day at the facility she engaged her call light and was told she would have to wait because her CNA had left for the day. She said there were multiple instances on various days when she engaged her call light and had to wait for up to an hour for her needs to be met.	F 725	Director initiated an in service with the Interim Director of Nursing and Staff Development nurse on the importance of following the facility assessment tool to ensure staffing levels meet the assessment needs of the residents. 4. Beginning February 17, 2025, the Staffing Coordinator will monitor any open shifts including weekdays/weekends to ensure adequate coverage for the facility. The staffing coordinator/supervisor will monitor call ins to ensure adequate coverage for the facility. Beginning February 17, 2025, the Executive Director initiated rounds three times weekly for six weeks, then weekly for six weeks interviewing five residents and five nursing staff to ensure sufficient staffing and care was provided. Any issues noted will be immediately addressed. The Executive Director will forward the results to the Quality Assurance Committee meeting. Starting February 26, 2025, the results will be reviewed monthly times three months. The Quality Assurance Committee meeting will make recommendations based on the findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255106	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON NURSING AND REHABILITATION CENTER	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 725	Continued From page 17	F 725		

Record review of the Facility Assessment Tool dated July 31, 2024 revealed that based on the facility's resident profile, the facility staffing plan revealed that based on resident population and their needs for care and support the total Number of staff needed to meet the needs of the residents at any given time included fifty-four (54) nurse aides (CNAs) per day and (26) to (34) licensed nurses providing direct care.

Record reviews of the facility provided staffing grid for 12/16/24 through 12/31/24 revealed the facility had fifty-three (53) CNAs on 12/16/24, fifty-one (51) CNAs on 12/23/24, fifty (50) CNAs on 12/25/24, fifty-three (53) CNAs on 12/26/24, forty-nine (49) CNAs on 12/27/24, fifty (50) CNAs on 12/28/24 and fifty (50) CNAs on 12/31/24. The facility had twenty-four (24) licensed nurses at the facility providing direct care on 12/24/24.

On 1/31/25 at 10:13 AM, during an interview the Housekeeping Supervisor reported that two (2) CNAs were "pulled" from resident care to work in the laundry due to staffing from 8:00 AM to 12:00 Noon on 1/31/25.

On 1/31/25 at 4:05 PM, during an interview the Staff Development Director stated that staff call-ins were a problem for provision of adequate staffing. She stated that she had never seen the Facility Assessment and was not aware of its use in scheduling nursing staff. She stated she "used the census" alone for planning staffing.

On 1/31/25 at 5:00 PM, during an interview the Director of Nurses (DON) said that call-ins were a problem at the facility, and it was up to her and the Staff Development Director to fill the positions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255106	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON NURSING AND REHABILITATION CENTER	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 725	Continued From page 18	F 725		

of nurses and CNAs who did not report as scheduled to provide adequate care for residents. She stated that she had not advised staff that it was acceptable to leave residents in bed or fail to provide showers/bathing for residents due to low staffing. She confirmed that staff arriving up to an hour or more late for their shifts could leave staffing levels low until they arrived. She stated she was not aware that CNAs were being "pulled" to work in the laundry due to lack of housekeeping staff and confirmed that practice could affect resident care.

On 1/31/25 at 5:13 PM, during an interview the Administrator said that the Staff Development Director was supposed to employ the Facility Assessment Tool when scheduling nursing staff to ensure adequate direct care staff to meet the needs of the residents based not only on census but resident needs and acuity as well. He said he was not aware that CNAs had been "pulled" to work in the laundry due to lack of housekeepers. He stated that he had hired six (6) new housekeepers between 1/28/25 and 1/31/25 but that they had not completed orientation at the time of interview. He confirmed that he had heard concerns voiced by residents and staff concerning staff arriving late, call-ins and not enough staff. The Administrator confirmed that he had completed the Facility Assessment Tool and that it was a useful aid to ensure adequate staffing and that he expected the Staff Development Director to use the tool when scheduling nurses and CNAs.

Record review of the Admission Record for Resident #1 revealed the facility admitted the resident on 12/06/24 and discharged the resident on 12/24/24. The resident had diagnoses of Heart

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255106	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON NURSING AND REHABILITATION CENTER	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 725	Continued From page 19 Failure, Chronic Obstructive Pulmonary Disease and Diabetes. Record review of the 5 Day Minimum Data Set (MDS) with Assessment Reference Date 12/13/24 for Resident #1 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated no cognitive impairment. Record review of the Admission Record for Resident #6 revealed the facility admitted the resident on 1/05/16 and the resident had diagnoses of Alzheimer's Disease, Dementia, and Anemia. Record review of the Annual MDS with ARD 12/12/24 revealed Resident #6 had a BIMS score of 5, which indicated the resident had severe cognitive impairment.	F 725		