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 03/06/2025

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 On 3/04/25 through 3/06/25 the State Agency (SA) conducted four (4) Complaint Investigations (CI MS #27867, CI MS #27938, CI MS #27980, CI MS #28004) at the facility. CI MS#27867 was investigated for Quality of Care related to staffing and other, and Physical Environment related to facility not clean. CI MS#27938 was investigated for Quality of Care related to residents not adequately groomed, inappropriate feeding assistance, Misappropriation and Resident Neglect related to medications. CI MS#27980 was investigated for Quality of Care related to resident left wet for extended periods and residents left soiled for extended periods, Resident Neglect related to medications and Quality of Care (other). CI MS#28004 was investigated for Resident Neglect related to medications, Quality of Care related to residents not adequately groomed and staffing, Dietary Services related to food served cold and not served timely, and Physical Environment related to facility not clean. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F550, F656, and F684 not related to the CI's. F676 was cited related to CI MS#27867 and CI MS#27938. At the time of the survey the facility was licensed for 230 beds and had a census of 221 residents.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and	F 550		3/31/25

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

Electronically Signed | 03/26/2025

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 03/06/2025

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 550	Continued From page 1 outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to	F 550	1) On March 4, 2025 Resident #5 was given a privacy bag to cover his Foley	

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 03/06/2025

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 550	Continued From page 2 ensure residents were treated in a dignified manner when Resident #5's urinary catheter bag was left uncovered with urine visible in a public common area for one (1) of eight (8) residents reviewed. Resident #5 Findings Included: Policy review of the facility-provided "Resident Bill of Rights" with Review Date 1/15 (January 2015) revealed the document stated, "It is the objective of the Facility to herein forth the rights of Residents so as to assure the protection and preservation of dignity... Facility Residents shall have the right to: 1. Privacy in treatment and personal care...26. Treated with consideration, respect, and full recognition of his/her dignity and individuality." Observation on 3/04/25 at 5:50 PM, in the Unit 2 Dining Room revealed Resident #5 was seated in a wheelchair with a urine collection bag beneath the wheelchair, uncovered, with approximately eighty (80) milliliters of golden yellow urine visible in the collection bag. Observation and interview on 3/06/25 at 11:20 AM, with the Administrator in Resident #5's room, the Administrator confirmed the resident did not have a privacy/dignity cover on his urine collection bag for his urinary catheter. Observation and interview on 3/06/25 at 11:35 AM, Licensed Practical Nurse (LPN) #4 confirmed that Resident #5 did not have a cover on his urine collection bag to ensure the resident's dignity. She stated that she was not aware of catheter care or monitoring prior to 3/06/25 because she was new to the facility.	F 550	Catheter drainage bag. On March 4, 2025, a 100% audit of residents who require a Foley catheter was conducted by the Unit Managers. On March 4, 2025, Licensed Practical Nurse (LPN) #5 was in serviced on importance of the preservation of dignity and rights regarding residents who require a urinary catheter bag. There were no ill effects noted. 2) Any residents who require a urinary catheter bag has the potential to be affected by this alleged deficient practice. 3) On March 4, 2025, all clinical staff in service was initiated on ensuring preservation of dignity and rights for all residents by the Staff Development Nurse. 4) On March 24, 2025, the Director of Nursing (DNS) and/or Assistant Director of Nursing (ADNS) initiated Foley Catheter audits of ten residents weekly for four weeks, then five residents weekly for two weeks. Any issues noted will be immediately addressed. The Director of Nursing will forward the results to the Quality Assurance Committee meeting. Starting March 31, 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 03/06/2025

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 550	Continued From page 3 Observation and interview on 3/06/25 at 2:35 PM, with the Minimum Data Set (MDS) Nurse revealed she was not sure if Resident #5 had a catheter. Observation of the resident in the Unit 2 Dining Room with the MDS Nurse confirmed that Resident #5 had an indwelling catheter. The MDS Nurse confirmed there should be a collection bag cover to ensure the privacy and dignity of the resident. In an interview on 3/06/25 at 3:08 PM, Registered Nurse (RN) #1, who is the Unit 2 Manager, stated that Resident #5 had the indwelling urinary catheter upon arrival at the facility on 1/15/25 and had the catheter in place since arrival. Record review of the Admission Record for Resident #5 revealed the facility admitted the resident on 1/15/25. The resident had diagnoses of Chronic kidney disease, Neuromuscular dysfunction of the bladder and Prostatic hyperplasia. Record review of the 5-Day MDS with an Assessment Reference Date (ARD) of 2/17/25 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment.	F 550		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		3/31/25

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 03/06/2025

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 656	Continued From page 4	F 656		

objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.

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 03/06/2025

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 656	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to develop and implement care plans for two (2) of eight (8) residents reviewed, Resident #5 and Resident #6. Findings Included: Policy review of the facility policy titled "COMPREHENSIVE PERSON-CENTERED CARE PLANS" dated 8/11 (August 2011) revealed "POLICY: Each resident will have a person-centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care..." Resident #5 Record review of the comprehensive care plan revealed there was not a care plan developed related to catheter care for Resident #5. Record review of the comprehensive care plan revealed "I am at risk for UTI's (urinary tract infections) and skin breakdown r/t (related to) bladder incontinence. Date Initiated 1/24/25 revealed there were no interventions that addressed the presence of an indwelling urinary catheter. Record review of comprehensive care plan included a new care plan initiated on 3/06/25 for "The resident has Foley Catheter related to dx (diagnosis) of BPH (benign prostatic hypertrophy)," with no mention of a collection bag cover.	F 656	1) On March 6, 2025, the care plan for Resident #5 was revised by Assistant Director of Nursing (ADNS) nurse to address the presence of an indwelling urinary catheter and the risks of resident #5 having the indwelling urinary catheter with a collection back cover. On March 5, 2025, resident #6 received ADL care which included a shower. The Assistant Director of Nursing (ADON) reviewed the shower schedule with Resident #6. The ADON revised the shower schedule, care plan and cardex per resident #6□s preference and offered a bed bath on non-shower days. 2) Any resident who has an indwelling catheter or needs assistance with Activities of Daily Living skills of showers has the potential to be affected by this alleged deficient practice. 3) On March 6, 2025, an in serviced was initiated for all clinical staff on following care plan for Activities of Daily Living skills regarding urinary catheter bags with cover bag and showering by the Staff Development nurse. The in services on following care plans regarding indwelling urinary catheter bags with cover and Activities of Daily Living skills of showering will be completed by April 4, 2025. 4) On March 24, 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 03/06/2025

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 656	Continued From page 6 Observation on 3/04/25 at 5:50 PM, in the Unit 2 Dining Room revealed Resident #5 was seated in a wheelchair with a urine collection bag beneath the wheelchair, uncovered, with approximately eighty (80) milliliters of golden yellow urine visible in the collection bag. Observation and interview on 3/06/25 at 11:20 AM, with the Administrator in Resident #5's room the Administrator confirmed the resident did not have a privacy/dignity cover on his urine collection bag for his urinary catheter. On 3/06/25 at 11:35 AM, Licensed Practical Nurse (LPN) #4 confirmed that Resident #5 did not have a cover on his urine collection bag to ensure the resident's dignity. She stated that she was not aware of catheter care or monitoring prior to 3/06/25 because she was new to the facility. On 3/06/25 at 2:35 PM, an interview and observation with the Minimum Data Set (MDS) Nurse said she was not sure if Resident #5 had a catheter. Observation of the resident in the Unit 2 Dining Room with the MDS Nurse confirmed that Resident #5 had an indwelling catheter. The MDS Nurse confirmed that she had not noted an indwelling catheter at the time of the admission assessment on or around 1/15/25. She confirmed that Resident #5 needed a care plan to address his indwelling urinary catheter and that the care plan should include the provision of a collection bag cover to ensure the privacy and dignity of the resident. On 3/06/25 at 3:08 PM, during an interview, Registered Nurse (RN) #1 who is the Unit 2 Manager, stated that Resident #5 had the indwelling urinary catheter upon arrival at the	F 656	Nursing (DNS) and/or Assistant Director of Nursing (ADNS) initiated care plan audits of ten residents with indwelling urinary catheters weekly for four weeks, then five residents weekly for two weeks. On March 24, 2025, the Director of Nursing (DNS) and/or Assistant Director of Nursing (ADNS) initiated interviews of ten residents weekly to ensure care plan shower compliance for four weeks, then five residents weekly for two weeks. Any issues noted will be immediately addressed. The Director of Nursing will forward the results to the Quality Assurance Committee meeting. Starting March 31, 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 03/06/2025

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 656	Continued From page 7	F 656		

facility on 1/15/25 and had the catheter in place since arrival.

Resident #6

Record review of the care plan for Resident #6 revealed "Focus: I have ADL (activities of daily living) self-care performance deficit r/t (related to) Dementia with behaviors ...requires extensive to total dependence with ADL's ...Interventions ...Assist with ADL's as needed or as requested ...Provide showers three (3) x weekly ..."

On 3/05/25 at 12:00 PM, during an interview, Resident #6 reported that he needed a shower. He said he was not provided with a shower on 3/04/25 or 3/05/25 and could not recall the last time he was taken to the shower room. He stated, "I need a shower, I don't want to just lay here and rot." He said he did not feel he should have to request to go to the shower because the staff had told him he was scheduled to go to the shower three times each week, so he felt they should already know.

On 3/05/25 at 12:05 PM, during an interview, Certified Nurse Aide (CNA) #5 revealed Resident #6 was supposed to be assisted with a shower three times each week and upon request. She stated that she was assigned to the care of Resident #6 and had not taken Resident #6 to the shower on Thursday, 3/05/25, because his showers were scheduled for Monday, Wednesday, and Friday on the Weekly Shower List. She stated that she was not assigned to the daily care of Resident #6 on Wednesday, 3/04/25. She was unable to determine the last time Resident #6 was taken to the shower. She stated that the resident was dependent on staff

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 03/06/2025

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 656	Continued From page 8	F 656		

for bath/shower activities and able to transfer with a mechanical lift into a shower chair. She stated that she was not aware of Resident #6 refusing care.

On 3/06/25 at 2:35 PM, an interview and observation with the MDS Nurse revealed that she and the other MDS nurses developed care plans for the residents and that any nurse could update the care plans as needed based on changes to the resident's condition. She stated the purpose of care plans was to provide instructions for taking care of residents and that the development and implementation of care plans were very important. She explained that care plans were entered into the computer software and selected care instructions were "pulled over" into the Kardex, which all CNAs had access to via facility computers available to them. She confirmed that on 3/06/25, she had removed the specific days from the care plan for Resident #6 and left the care plan intervention as "Provide Showers three (3) times weekly."

On 3/06/25 at 4:45 PM, during an interview, the Director of Nurses (DON) confirmed that Resident #5 had an indwelling catheter and no care plan for catheter care. She confirmed that a discrepancy between the resident's care plan and the Weekly Shower List may have caused Resident #6 to miss scheduled showers.

On 3/06/25 at 5:30 PM, during an interview, the Administrator confirmed the expectation that each resident be assessed upon admission, with reconciliation of the visual assessment, physician orders, and diagnoses. He confirmed that he expected individual care plans for each resident to be developed and implemented based on

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 03/06/2025

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 656	Continued From page 9 resident needs and abilities.	F 656		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech,	F 676		3/31/25

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 03/06/2025

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 676	Continued From page 10 (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and interviews, the facility failed to provide necessary care for hygiene, bathing, and grooming for two (2) of eight (8) sampled residents, Resident #4 and Resident #6. Findings Included: Record review of the facility policy titled "SHAVING-MALE AND FEMALE" dated 8/11 (August 2011) revealed the policy stated, "POLICY: Residents will be free of facial hairs - both male and female. If the resident is alert and oriented and requests not to be shaved, this will be noted in the Care Plan. RESPONSIBILITY: All Nursing Assistants monitored by Charge Nurse." Record review of the facility policy titled "BATH/SHOWER-DEPENDENT" dated 8/11 (August 2011) revealed, "POLICY: A bath (shower/tub) for cleanliness and comfort is scheduled at least weekly for each resident. RESPONSIBILITY: Nursing Assistants or Licensed Nurses monitored by Charge Nurse..." Resident #4 On 3/04/25 at 3:10 PM, observation revealed Resident #4 was seated in the Unit 1 Dining/Activity Room across from the nurses' station with a long white mustache and beard. The resident was pulling his mustache into his mouth with his tongue. His mustache hair was long enough to curl over his top lip into his mouth. He reported that the long mustache hairs were	F 676	1) On March 4, 2025, resident #4 received Activities of Daily Living skills which included grooming by trimming his mustache. On March 4, 2025, Resident #6 received a shower. On March 4, 2025, the Assistant Director of Nursing (ADON) reviewed the shower schedule with Resident #6. The ADON revised the shower schedule and kardex per resident #6□s preference and offered a bed bath on non-shower days. 2) Any resident that requires Activities of Daily Living skills of mustache grooming and showers have the potential to be affected by this alleged deficient practice. 3) On March 4, 2025, an in-service was initiated for all nursing staff by the Staff Development nurse on the importance of residents receiving Activities of Daily Living skills of mustache grooming and showers. The in services on Activities of Daily Living skills of mustache grooming and showers will be completed by April 4, 2025. 4) On March 24, 2025, the Director of Nursing (DNS) and/or Assistant Director of Nursing (ADNS) initiated mustache grooming audits of ten residents weekly for four weeks, then five residents weekly	

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 03/06/2025

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 676	Continued From page 11 too long and were bothering him. He said they interfered with his eating. He said that he wished someone would trim them for him. On 3/04/25 at 3:20 PM, an interview with Certified Nurse Aide (CNA) #1, CNA #2, CNA #3, and CNA #4 revealed all reported that grooming was traditionally done during AM and PM care, with shaving/unwanted hair removal done during showers, but that Activities of Daily Living (ADL) and grooming care could be provided at any time. On 3/04/25 at 3:35 PM, an interview with Licensed Practical Nurse (LPN) #2 and LPN #3 revealed nurses and Unit Managers supervise the care of residents to ensure care is provided according to the resident needs and abilities. Resident #6 During an interview on 3/04/25 at 4:30 PM, Resident #6 revealed the resident reported that he needed a shower. He stated that he was scheduled to have a shower three (3) times each week and had not been taken to the shower for at least two (2) weeks. During an interview on 3/05/25 at 12:00 PM, Resident #6 reported that he needed a shower. He said he was not provided with a shower on 3/04/25 or 3/05/25 and could not recall the last time he was taken to the shower room. He stated that the nursing staff had told him that he was not going to the shower because the facility no longer had a shower bed. He stated, "I need a shower, I don't want to just lay here and rot." He said he did not feel he should have to request to go to the shower because the staff had told him he was scheduled to go to the shower three times each	F 676	for two weeks. On March 24, 2025, the Director of Nursing (DNS) and/or Assistant Director of Nursing (ADNS) initiated interviews of ten residents weekly to ensure shower compliance for four weeks, then five residents weekly for two weeks. Any issues noted will be immediately addressed. The Director of Nursing will forward the results to the Quality Assurance Committee meeting. Starting March 31, 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 03/06/2025

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 676	Continued From page 12	F 676		

week, so he felt they should already know.

During an observation and interview on 3/05/25 at 12:05 PM, CNA #5 revealed that Resident #6 was supposed to be assisted with a shower three times each week and upon request. She explained that the CNAs also used the printed Weekly Shower List located at the nurses' station as a guide for which residents were provided with showers each day. She stated that she was assigned to the care of Resident #6 and had not taken Resident #6 to the shower on Thursday, 3/05/25, because his showers were scheduled for Monday, Wednesday, and Friday on the Weekly Shower List. She stated that she was not assigned to the daily care of Resident #6 on Wednesday, 3/04/25. She was unable to determine the last time Resident #6 was taken to the shower. She stated that the resident was dependent on staff for bath/shower activities and able to transfer with a mechanical lift into a shower chair.

During an observation and an interview on 3/06/25 at 4:30 PM, with the Administrator and LPN #1 revealed there was one (1) black and white shower bed labeled by the manufacturer with a five hundred (500) pound weight limit and one (1) shower chair in the Unit 1 shower room, which were available for all staff/resident use. LPN #1 stated that Resident #6 could use either the shower bed or shower chair. She confirmed the resident was to receive a shower every Tuesday, Thursday, and Saturday, and the printed Weekly Shower List at the nurses' station stated that the resident was to receive a shower every Monday, Wednesday, and Friday, but that regardless, the resident was to be provided with a shower three (3) times weekly and as requested.

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 03/06/2025

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 676	Continued From page 13 The Administrator stated the shower bed was stored in the Unit 1 shower room because there were more residents who required it, but that it was available for all units' use. During an interview on 3/06/25 at 4:45 PM, the Director of Nurses (DON) stated that it was important for staff to identify the residents' needs and abilities at the time of admission and on an ongoing basis and that she expected care to be provided. During an interview on 3/06/25 at 5:30 PM, the Administrator confirmed that he expected each resident to be assessed upon admission with reconciliation of the visual assessment, physician orders, and diagnoses. He confirmed that he expected care to be provided.	F 676		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to meet current professional standards of care as evidenced by no physician order written for a resident who had an indwelling foley catheter for one (1) of eight (8) residents reviewed. Resident	F 684	1) On March 4, 2025 Resident #5 received a doctors□ order by the charge nurse for a Foley Catheter drainage bag. The Assistant Director of Nursing assessed Resident #5. There were no ill effects.	3/31/25

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 03/06/2025

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 684	Continued From page 14 #5. Findings Included: Policy review of the facility policy titled "PHYSICIAN ORDERS" dated 1/25 (January 2025) revealed "Orders received from a physician must be written on a hard script and signed by a physician. RESPONSIBILITY: All Licensed Nursing Personnel..." During an observation on 3/04/25 at 5:50 PM, in the Unit 2 Dining Room revealed Resident #5 was seated in a wheelchair with a urine collection bag beneath the wheelchair, uncovered, with approximately eighty (80) milliliters of golden yellow urine visible in the collection bag. During an observation and interview on 3/06/25 at 11:20 AM, the Administrator confirmed the resident did not have a privacy/dignity cover on his urine collection bag for his urinary catheter. During an interview on 3/06/25 at 11:35 AM, Licensed Practical Nurse (LPN) #4 confirmed that Resident #5 did not have a cover on his urine collection bag to ensure the resident's dignity. She stated that she was not aware of catheter care or monitoring prior to 3/06/25. During an interview and observation on 3/06/25 at 2:35 PM, the Minimum Data Set (MDS) Nurse revealed she was not sure if Resident #5 had a catheter. Observation of the resident in the Unit 2 Dining Room with the MDS Nurse confirmed that Resident #5 had an indwelling catheter. She confirmed that there were no physician orders for a catheter for Resident #5.	F 684	2) Any residents who require a Foley Catheter drainage bag has the potential to be affected by this alleged deficient practice. 3) On March 4, 2025, a 100% audit was conducted to ensure residents with an indwelling urinary catheter have a physician□s order by the Unit Managers. On March 4, 2025, an in-service was initiated for all facility nurses including Registered Nurses and Licensed Practical Nurses on ensuring residents with an indwelling urinary catheter have a physician□s order by the Staff Development Nurse. 4) On March 24, 2025, the Director of Nursing (DNS) and/or Assistant Director of Nursing (ADNS) initiated audits of ten residents with indwelling urinary catheter to ensure a physician□s order weekly for four weeks, then five residents weekly for two weeks. Any issues noted will be immediately addressed. The Director of Nursing will forward the results to the Quality Assurance Committee meeting. Starting March 31, 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 03/06/2025

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 684	Continued From page 15	F 684		

During an interview on 3/06/25 at 3:08 PM, Registered Nurse (RN) #1 who is the Unit 2 Unit Manager, stated that Resident #5 had the indwelling urinary catheter upon arrival at the facility on 1/15/25 and had the catheter in place since arrival.

Record review of the "Order Summary Report" with active orders of 3/6/25 revealed the resident had no physician's order for a urinary catheter. Resident #5's orders included an order for "Foley catheter care every shift" with an order date and start date of 3/04/25. There were no other orders for the catheter noted.

During an interview on 3/06/25 at 4:45 PM, the Director of Nurses (DON) stated that it was important for staff to identify the residents' needs and abilities at the time of admission and on an ongoing basis. She explained that the nurses used the Physician Orders, Care Plans, and Treatment Administration Record as a guide for providing resident care. She stated that the RN's, Unit Managers, and she supervised the care of residents and that she expected care to be provided in accordance with the residents' physician orders. She confirmed that Resident #5 had an indwelling catheter with no physician's order in his medical record for the catheter.

During an interview on 3/06/25 at 5:30 PM, the Administrator confirmed that he expected each resident to be assessed upon admission with reconciliation of the visual assessment, physician orders, and diagnoses. The Administrator confirmed that meeting these expectations was necessary for care to be provided according to current standards of practice.

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 03/06/2025

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 684	Continued From page 16 Record review of the Admission Record for Resident #5 revealed the facility admitted the resident on 1/15/25. The resident had diagnoses of Chronic kidney disease, Neuromuscular dysfunction of the bladder and Prostatic hyperplasia. Record review of the 5-Day Minimum Data Set (MDS) for Resident #5 with an Assessment Reference Date (ARD) of 2/17/25 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment.	F 684		