

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

PRINTED: 06/06/2025
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 04/22/2025
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 a Complaint Investigation (CI), MS #28645, at the facility, from 4/21/25 through 4/22/25. MS #28645 was investigated related to assessing and monitoring a resident. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F684 and F656.	F 000			
F 656 SS=G	The facility was licensed for 230 beds, with a census of 217. Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not 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	F 656		5/30/25	

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

TITLE

(X6) DATE

Electronically Signed

05/09/2025

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.

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F 656	Continued From page 1 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to implement the resident's care plan interventions related to daily skin and foot assessments for one (1) of four (4) residents reviewed for care planning, Resident #1, which resulted in the facility not identifying or addressing developing wounds on the resident's foot, which remained untreated by facility staff for five (5) days after being discovered and treated at the dialysis center. Findings include: Record review of facility "Comprehensive Person-Centered Care Plan" policy dated	F 656	1) On April 21, 2025, the care plan for Resident #1 was revised by Assistant Director of Nursing (ADNS) to perform weekly skin assessments. 2) All Residents with treatment care plans have the potential to be affected by this alleged deficient practice. 3) On April 21, 2025, a 100% audit of Residents' care plans who receive weekly skin assessments were revised by the Assistant Director of Nurses. On April 21, 2025, an in- service was initiated by the Staff Development Nurse was for all		

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F 656	Continued From page 2 01/2025 revealed " ...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 ...Procedure ...6. Staff approaches are to be developed for each problem/strength/need ...Assigned disciplines will be identified to carry out the intervention ..." A record review of the "Care Plan Report" for Resident #1 revealed a "Focus" of "(Proper Name) has a dx (diagnosis) of Diabetes Mellitus with interventions including "Check all of body for breaks in skin and treat promptly ..." and "Inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness," both initiated on 10/15/24. A record review of the "Clinical Notes Report" from the dialysis center revealed on 4/16/25 at 11:25 (AM) RN #2 documented that "Noted today that (Proper Name of Resident) sock on rt (right) foot had some drainage and the sock was stuck to his great toe and the second toe. Skin was missing in two areas. Color of toes are black in areas. Dead skin filled his sock. Foot very dry. Pressure areas cleaned and betadine applied with a non adhesive bandaid. (Proper Name of Nursing Facility) called and the nurse assigned to (Proper Name of Resident) was given this report and that he will need to be seen in their wound care department. She report she would get the wound care doctor to evaluate." A record review of the facility's "Weekly Skin" assessments revealed there was no documentation of any wounds to the right foot on 4/16/25 at 2:34 PM, which was after Resident #1 had returned from dialysis in which he received	F 656	clinical staff on following the care plan of all Residents who have treatment orders. The in-services on following resident care plans who receive weekly will be completed by May 13, 2025. 4) On April 21, 2025, the Director of Nursing (DNS) and/or Assistant Director of Nursing (ADNS) initiated audits of ten residents for following care plan of residents who receive weekly skin assessments weekly for six weeks, then five residents weekly for six weeks. The Director of Nursing will forward the results to the Quality Assurance Committee meeting. Starting May 28, 2025, the results will be reviewed monthly for three months. The Quality Assurance committee meeting will make recommendations based on the findings.		

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F 656	Continued From page 3 treatments to the right foot wounds. The assessment was completed by LPN #2. During an observation at the dialysis facility on 04/21/25 at 11:15 AM, Resident #1 had dry scaly feet, thickened dark toenails, and a bandage across the toes dated 04/18/25. Further observation revealed a discolored area on the great toe and missing skin on the second toe. The dialysis nurse confirmed that the bandage was the same one placed on 04/18/25 by her staff. The dialysis nurse stated that although the socks had been changed, the dressing had not been replaced. During an interview on 04/22/25 at 09:30 AM, Licensed Practical Nurse (LPN) #2, who serves as the wound care nurse for Resident #1, it was revealed that the resident's care plan directed daily foot checks for open areas, sores, blisters, etc. LPN #2 stated she was not aware of any calls from an outside agency advising of issues regarding the resident's foot. She confirmed that she completed the body audits 04/16/25 after the resident had returned from dialysis and acknowledged that there was no mention of the wounds documented. After reviewing the dialysis center's documentation dated 4/16/25 regarding Resident #1's wounds, she stated she could neither confirm nor deny that she actually completed the skin check. During an interview on 04/22/25 at 9:56 AM, the facility's Wound Care Physician and LPN #3, they stated they were contracted specialists responsible for providing wound care services to the facility. The Wound Care Physician reported he received a new consultation order for Resident #1 on 04/21/25 at 2:52 PM and stated he had not	F 656			

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F 656	Continued From page 4 previously assessed or treated Resident #1 prior to that date. He explained that he first evaluated Resident #1 between 6:00 AM and 7:00 AM on 04/22/25. During an interview on 04/22/25 at 10:00 AM, the facility's Director of Nursing (DON), she acknowledged that staff failed to implement interventions related to Resident #1's care plan regarding skin assessments and foot checks. The DON stated that although the dialysis staff notified the facility of concerns regarding potential skin breakdown and wounds, facility staff did not implement necessary interventions. The DON stated that if the audits had been completed properly, the dressing applied by the dialysis center should have been identified, prompting immediate documentation, further assessment, and medical intervention. During an interview on 04/22/25 at 3:00 PM, facility's Licensed Nursing Home Administrator (LNHA), he stated it was his expectation that staff implement a resident's care plan and promptly report any changes in a resident's condition to the resident's physician, the Director of Nursing (DON), and to himself. A record review of the "Admission Record" revealed the facility admitted Resident #1 on 10/4/2017 with current diagnoses including End Stage Renal Disease. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/12/2025, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated he had severe cognitive impairment.	F 656			

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F 684 SS=G	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 provide necessary care and services and respond appropriately to changes in a resident's condition for one (1) of four (4) sampled residents (Resident #1), when wounds were identified and treated by the dialysis clinic on 4/16/25 and the facility was notified, but failed to assess or initiate treatment until 4/21/25, resulting in a delay in care and placing the resident at risk for a worsening wound condition and infection. Findings include: A review of the facility's policy, "Weekly Skin Audit", dated 11/17, revealed, " ...A skin audit will be documented on residents weekly. Any identified skin conditions will be documented and treatment initiated ...Procedure: 1. Every resident will have a head-to-toe skin evaluation performed and documented on a weekly basis. The evaluation will be documented electronically or on the weekly skin audit form ..." A review of the facility's policy, "Preventative Skin Care", dated 01/15, revealed: "It is the practice of	F 684	1) On April 21, 2025, Resident #1 was immediately assessed by the DNS. On April 21, 2025, a treatment order was received for Resident #1 by the Medical Doctor and a wound care consult order was given by the Nurse Practitioner (NP) The wound care doctor assessed Resident #1 and on 04/22/25. No new orders received. 2) All residents with treatment orders have the potential to be affected by this alleged deficient practice. 3) April 21, 2025, an in service was initiated for all clinical staff to ensure weekly skin assessments and treatments are provided as ordered for all residents by the Staff Development Nurse. The in services on ensuring weekly skin assessments are completed and any areas identified requiring treatment have treatment orders in place, will be completed by May 13, 2025. A 100% skin	5/30/25	

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F 684	Continued From page 6 this facility to provide routine preventive skin care. This policy will serve as a guide to facilitate staff with regard to clinically acceptable techniques to be applied for skin care prevention ...Procedure ...4. Provide preventative skin care to all residents. The following interventions should be considered for incorporation into residents' care plans (this is not an all-inclusive list): a. Keep skin clean, dry, and cleansed at the time of soiling and at routine intervals ...d. Moisturize skin with lotion to keep skin soft and pliable, giving special attention to participate in prevention ..." On 04/21/25 at 10:35 AM, during an interview with Registered Nurse (RN) #2 and RN #1 at the dialysis center, RN #2 explained that she was contacted by a staff nurse who had performed a routine foot check on Resident #1. She stated that the resident's sock on the right foot was visibly soiled with drainage and adhered to his great toe and second toe. Upon removal, skin was noted to be missing in two areas, the toes showed black discoloration, and the upper foot was covered with a significant amount of dry, dead skin. RN #2 stated that the pressure areas were cleaned, Betadine was applied, and a non-adhesive bandage was placed over the wounds. She reported that the nursing facility was notified, and the nurse assigned to Resident #1 was informed that the resident required follow-up from the facility's wound care team. RN #2 stated that the nurse at the facility indicated she would contact the wound care physician to evaluate the resident. RN #1 confirmed that she also received a report that wounds with necrotic tissue had been identified during the foot check and interviewed Resident #1, who reported that staff at the facility changed his socks approximately every two weeks, bathed him once per week, and	F 684	audit was completed on all residents to ensure all areas requiring treatment's, have treatment orders in place, were completed by 4-28-2025, with no additional area found. 4) On April 21, 2025, the Director of Nursing (DNS) and/or Assistant Director of Nursing (ADNS) initiated audits of ten residents who require treatment orders weekly for six weeks, then five residents weekly for six weeks. The Director of Nursing will forward the results to the Quality Assurance Committee meeting. Starting May 28, 2025, the results will be reviewed monthly for three months. The Quality Assurance committee meeting will make recommendations based on the findings.		

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F 684	Continued From page 7 changed his incontinent briefs two to three times daily. RN #1 stated that the concern was reported to the State Agency (SA) and that she and the charge nurse (CN) maintained communication with the facility. She added that after dressing the wounds, the CN placed marked gauze inside the resident's sock in order to assess whether the bandages and socks would be changed prior to the resident's next dialysis visit. On 04/21/25 at 11:00 AM, during an interview, Resident #1 stated that he typically receives bed baths once a week and that his incontinent brief is changed two to three times a day. He acknowledged that on 04/16/25, the nursing staff at the dialysis unit removed his sock and the sock had to be soaked so it could be removed. Resident #1 further acknowledged that the dialysis staff informed him of a possible wound and advised him to follow up with the wound care nurse at his facility. He reported that no one from the facility had checked the dressing on his foot, nor had a doctor evaluated it. He stated that the only dressing changes performed were by the dialysis facility. On 04/21/25 at 11:15 AM, during an observation at the dialysis facility, Resident #1 had dry scaly feet, thickened dark toenails, and a bandage across the toes dated 04/18/25. Further observation revealed a discolored area on the great toe and missing skin on the second toe. The dialysis nurse confirmed that the bandage was the same one placed on 04/18/25 by her staff. The dialysis nurse stated that although the socks had been changed, the dressing had not been replaced. On 04/21/25 at 12:23 PM, during an interview			F 684			

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F 684	Continued From page 8 with the facility's Unit Manager, Licensed Practical Nurse (LPN) #1, she stated she had not been informed of any foot issues concerning Resident #1. A review of the 24-hour nursing reports dated 04/16/25 through 04/18/25 revealed no documentation of any communication from the dialysis center regarding foot concerns. Further review of the electronic medical record showed no evidence that a provider had been notified about the resident's foot condition, nor was there documentation of any nursing interventions implemented to address or safeguard the resident's foot health. LPN #1 stated that concerns of this nature should have been documented in the 24-hour report, communicated to the physician in real time, and appropriate medical orders obtained. On 04/22/25 at 09:30 AM, during an interview with the Licensed Practical Nurse (LPN) #2, who serves as the wound care nurse for Resident #1, it was revealed that the resident's care plan directed daily foot checks for open areas, sores, blisters, etc. LPN #2 stated she was not aware of any calls from an outside agency advising of issues regarding the resident's foot. She confirmed that she completed the body audits 04/16/25 after the resident had returned from dialysis and acknowledged that there was no mention of the wounds documented. After reviewing the dialysis center's documentation dated 4/16/25 regarding Resident #1's wounds, she stated she could neither confirm nor deny that she actually completed the skin check. On 04/22/25 at 9:56 AM, during an interview with the facility's Wound Care Physician and LPN #3, they stated they were contracted specialists responsible for providing wound care services to	F 684			

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F 684	Continued From page 9 the facility. The Wound Care Physician reported he received a new consultation order for Resident #1 on 04/21/25 at 2:52 PM and stated he had not previously assessed or treated Resident #1 prior to that date. He explained that he first evaluated Resident #1 between 6:00 AM and 7:00 AM on 04/22/25. During the assessment, he described a macule on the resident's great toe as a dry, discolored, palpable area that was not open and had no depth. He stated he also assessed the resident's second toe, which exhibited hyperpigmentation, potentially an early sign of ischemia (lack of blood flow), and described it as "dry with darkened skin." The physician emphasized the importance of weekly body audits and stated that he had received consultation requests for other residents based on findings from nursing staff during these audits. He also noted that he had telehealth capabilities available to evaluate urgent concerns remotely and that he visited the facility in person at least once per week. On 04/22/25 at 10:00 AM, during an interview with the facility's Director of Nursing (DON), she acknowledged that staff failed to ensure appropriate wound care, monitoring, and follow-up actions were taken for Resident #1. The DON stated that although the dialysis staff notified the facility of concerns regarding potential skin breakdown and wounds, facility staff did not implement necessary interventions, notify the physician, or initiate appropriate care. She further explained that weekly body audits are conducted for all residents and are expected to include a thorough head-to-toe assessment. The DON stated that if the audits had been completed properly, the dressing applied by the dialysis center should have been identified, prompting	F 684			

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F 684	Continued From page 10 immediate documentation, further assessment, and medical intervention. On 04/22/25 at 3:00 PM, during an interview with the facility's Licensed Nursing Home Administrator (LNHA), he stated it was his expectation that nursing staff promptly report any changes in a resident's condition to the resident's physician, the Director of Nursing (DON), and to himself, as appropriate. A record review of the "Admission Record" revealed the facility admitted Resident #1 on 10/4/2017 with current diagnoses including End Stage Renal Disease. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/12/2025, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated he had severe cognitive impairment. A record review of the "Clinical Notes Report" from the dialysis center revealed on 4/16/25 at 11:25 (AM) RN #2 documented that "Noted today that (Proper Name of Resident) sock on rt (right) foot had some drainage and the sock was stuck to his great toe and the second toe. Skin was missing in two areas. Color of toes are black in areas. Dead skin filled his sock. Foot very dry. Pressure areas cleaned and betadine applied with a non adhesive bandaid. (Proper Name of Nursing Facility) called and the nurse assigned to (Proper Name of Resident) was given this report and that he will need to be seen in their wound care department. She report she would get the wound care doctor to evaluate." On 4/16/25 at 11:48 (AM), RN #3 documented, " ...In between	F 684			

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

PRINTED: 06/06/2025
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 04/22/2025
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 684	Continued From page 11 RT (right) toe and Second toe area is back. Skin breakdown noted to Rt Great Toe and Second toe. Pt sock was stuck to toes ..."On 4/16/25 at 13:22 (1:32 PM), RN #1 documented, " ...Rn and CN (Charge Nurse) have communicated with facility, facility states they will get wound care for patient, CN put marked gauze in patient's sock after dressing wounds to see if dressing and/or sock are changed at next visit ..." A record review of the "Clinical Notes Report" from the dialysis center revealed on 4/18/25 at 13:22 (1:32 PM), RN #2 documented, "Noted today when this RN did a recheck on patient's right foot wound: same sock on foot, same gauge and bandage we applied on foot Wednesday 4/16/25 was discovered ..." On 4/18/25 at 13:38 (1:38 PM), RN #1 documented, "CN checked patient's foot to see if marked gauze was still in sock or wound dressing was changed. The marked gauze was still in patient's sock and dressing had not been changed. CN changed dressing again and placed new marked gauze, will recheck Monday." A record review of the facility's "Weekly Skin" assessments revealed there was no documentation of any wounds to the right foot on 4/16/25 at 2:34 PM, which was after Resident #1 had returned from dialysis in which he received treatments to the right foot wounds. The assessment was completed by LPN #2. A record review of the "Surgical Note", dated 4/22/25, for Resident #1 revealed a "Wound Location" of "Right great toe" that measured 0.4 centimeters (cm) x 0.4 cm x 0.0 cm wound, area 16 cm². Another "Wound Location" of right second toe that measured 5.0 cm x 2.0 cm x 0.0	F 684			

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F 684	Continued From page 12 cm wound, area 10 cm².	F 684			