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 _____	R-C 04/23/2025

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 a revisit/follow-up survey, from 4/22/25 through 4/23/25, at the facility for the Complaint Investigation (CI) Survey conducted on 3/06/25. The SA determined the facility took measures to correct these deficiencies as of 3/31/25, however, the facility remains out of compliance due to deficiencies cited on the 4/01/25 and 4/22/25 surveys. At the time of the follow-up survey the facility was licensed for 230 beds and had a census of 217 residents.	{F 000}		
{F 656} SS=G	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	{F 656}		6/7/25

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

Electronically Signed | 05/10/2025

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 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. This REQUIREMENT is not met as evidenced by: The State Agency (SA) conducted a revisit/follow-up survey, from 4/22/25 through 4/23/25, at the facility for the Complaint Investigation (CI) Survey conducted on 3/06/25. The SA determined the facility took measures to correct these deficiencies as of 3/31/25, however, the facility remains out of compliance due to deficiencies cited on the 4/01/25 and 4/22/25 surveys.	{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 Kardex per resident #6□s preference and offered a bed bath on	

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{F 656}	Continued From page 2	{F 656}	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 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.	

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{F 656}	Continued From page 3	{F 656}	The Quality Assurance committee meeting will make recommendations based on the findings.	
{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: The State Agency (SA) conducted a revisit/follow-up survey, from 4/22/25 through 4/23/25, at the facility for the Complaint Investigation (CI) Survey conducted on 3/06/25. The SA determined the facility took measures to correct these deficiencies as of 3/31/25, however, the facility remains out of compliance due to deficiencies cited on the 4/01/25 and 4/22/25 surveys.	{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. 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	6/7/25

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{F 684}	Continued From page 4	{F 684}	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.	