STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255106	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON NURSING AND REHABILITATION CENTER	355 CROSSGATE BLVD , BRANDON, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI) MS #2614966 and Facility Reported Incident # 2615381 at the facility on 10/2/25 related to reporting abuse in a timely manner. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F609. The facility held a license for 230 beds, with a census of 201.	F0000		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F0609		

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 reverse for further 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.

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

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F0609 SS = D	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review and facility policy review, the facility failed to report allegations of abuse for one (1) of three (3) residents reviewed. Resident #1 Findings include: A record review of the facility's "Abuse Prevention" policy with a revision date of 1/25 revealed alleged violations involving abuse, neglect… are reported immediately, but not later than 2 hours after the allegation is made. On 10/2/25 at 11:15 AM in an interview with the Director of Nursing (DON) she stated that on 9/7/25 Certified Nursing Assistant (CNA) #2 told her that CNA #1 asked for help giving Resident #1 a bed bath. She stated the resident is blind and deaf. She stated they communicate by writing simple words in the resident hands with their fingers to let her know what they are doing. CNA #1 tried to sit the resident up on the side of the bed and the resident's foot was stuck in the bedrail. The resident sleeps at the foot of the bed. She stated CNA #1 did not see that the resident's right foot was stuck in the bedrail. CNA #2 saw it and told CNA #1 to stop. She stated the resident became combative during care. She started to swing her arms. She stated CNA #1 stopped, and CNA #2 rubbed the resident's arm attempting to get her to calm down. CNA #2 did not report it to the nurse on duty. She stated at that time CNA #2 did not tell her that CNA #1 hit the resident. She stated they gave resident time to calm down. Resident #1 started swinging at staff again and hit CNA #2 in the face and left eye. She stated CNA #2 continued with care and CNA #1 grabbed the resident's arm to stop her from hitting them. She told CNA #1 that she needed a written statement. DON stated she was off on 9/10/25. She stated she was only told about resident hitting staff. She stated what CNA #2 told her on 9/8/25 was different than what she wrote in her statement. She stated she did not read CNA #2's written statement until 9/11/25 when she returned to work. On 10/2/25 at 11:43 AM in an interview with CNA #2 stated CNA #1asked her to help her give Resident #1 a shower. She stated CNA #1 tried to sit Resident #1 up on the side of the bed. The resident's foot was stuck in the bedrail. She told CNA #1 to stop due to the resident's foot being stuck. She stated she removed Resident #1's foot from the rail. CNA #1 was trying to remove the resident's bra, undershirt and pajama top	F0609		

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F0609 SS = D	Continued from page 2 all at the same time. Resident #1became combative. She hit her in the eye, and she stopped and backed up. Resident #1 was throwing hands into the air and CNA #1started to hit resident back. She stated she did not say or do anything she was in shock. She stated CNA #1stated out loud “This is why I only have one child, because of bitches like you.” She stated she told CNA #1 to stop, and she rubbed resident’s shoulder, and she completed the care. The resident calmed down and let her complete care. CNA #1 would not assist with complete care. She stated she did not feel comfortable telling the nurses on duty. She stated the resident became combative because of the way CNA #1 was handling the resident rough. CNA #2 said she told DON about CNA #1 hitting resident on 9/8/25. On 10/2/25 at 1:29 PM an interview with the Executive Director of the facility stated that the DON told her CNA #2 only told her about Resident #1’s foot getting stuck in the rail on 9/8/25 and was supposed to write a statement. She stated the statement was written on 9/8/25 and turned it in to the Assistant Executive Director (AED) #1 on 9/10/25. She stated she did not know about it until 9/11/25. She stated CNA #2 gave the statement to another CNA and that CNA gave it to AED #1 She stated AED #1 did not read the statement, she gave it to AED #2 on 9/11/25. She stated AED #2 slid it under her door of her office and she got it 9/11/25 that morning. She stated that she reported it to the State Agency (SA), started the investigation, and contacted the family. She confirmed that the facility must report an allegation of abuse within two hours of finding out about the alleged incident. She stated she was not aware of the alleged incident until she got the note that was slid under her door on 9/11/25. She stated the Resident Representative (RR) was in the building and she spoke with her on that day. She stated she also contacted local police department and the Attorney General’s office on 9/11/25. On 10/2/25 at 1:50 PM in an interview with AED #1 stated on 9/8/25 she left the facility for a physician appointment that afternoon and did not return. She stated CNA #2 called her and asked her if she could write on the back of the witness form. She stated she told the CNA yes and talked to the DON. She stated CNA #2 told her about the allegations of abuse. She stated she texted CNA #2’s number to the ED on 9/8/25. She stated the ED received the message and responded back and asked her which CNA was this. AED #1 looked at her phone and stated my text message to the ED stated CNA #2 name and phone number and included “call CNA”. She stated CNA #2 called her after her shift. CNA #2 was told to write a statement on 9/8/25 but did not write	F0609		

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F0609 SS = D	Continued from page 3 the statement until 9/10/25. She stated CNA #2 gave her a statement and she did not read it. She thought that it was about the CNAs assignment on unit 4. She stated CNA #2 was complaining earlier that day about her assignment. She stated AED #2 is over unit 4. She stated she gave the statement to AED #2. She stated it was not sealed in an envelope. She stated the written statement was given to ED #2 on 9/10/25 in the morning. On 10/2/25 at 2:12 PM in a phone interview with CNA #1 stated Resident #1 is blind, and combative. She stated she went to get help from CNA #2 to give Resident #1 a bed bath. She stated CNA #2 was holding the resident's hands. They were trying to do care. We were doing peri care on the bottom and the resident started fighting us. She stated resident kicked her in the stomach. She stated they have been trained to hold residents' hands if they become combative during care. She stated we don't have time to rub her during care to calm her down. She stated she was told to make to get resident bathe no matter what the outcome is. She stated during care that day the resident kicked her in the stomach, scratched her cheek and spit on her. She stated the resident can hear and see some. She stated she reported to the nurse after care about the resident scratching her cheek and becoming combative. She stated the nurse told her she would make a note of it. She denied hitting, cursing and handling her rough. On 10/2/25 at 2:29 PM in an interview with AED #2 stated she received a statement from AED #1 about CNA #1 pulling resident up roughly, Resident #1 swinging at staff and CNA #1 was hitting resident on the arm. She stated she gave the statement to the ED Tuesday or Wednesday morning. She stated CNA #2 gave the statement to AED #1 and AED #1 gave it to her. She stated she read the statement and gave it directly to the ED. She stated "I put the statement in the ED's hand. I did not slide it under the door." On 10/2/25 at 3:09 PM in an interview with AED #1 stated she can address the allegation, report it to the State Agency (SA) and suspend staff. On 10/2/25 at 3:21 PM in an interview with AED #2 stated the ED is the Abuse Coordinator and has been told she can report it if the ED is absent. She stated, "The ED was here, and I gave it to her." On 10/2/25 at 4:30 PM in an interview with the ED stated the DON or any assistant can do the report. On 10/2/25 at 4:32 PM in an interview with the DON stated she was told by the previous ED that she could	F0609		

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F0609 SS = D	Continued from page 4 report allegations of abuse or neglect. She stated she has not been told that by the present ED. A record review of Resident #1 “Admission Record” revealed an admission date of 7/22/20 with diagnosis of Epilepsy, unspecified, not intractable, without status Epilepticus. Cerebral Edema, Neurofibromatosis, Type 2 Unspecified Visual Loss and Unspecified Hearing Loss Unspecified Ear. A record review of Resident #1 Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/13/25 revealed section C revealed that Resident #1 is rarely/never understood. A record review of the facility ‘Supervisor Investigation Summary form revealed the investigation was initiated on 9/8/25 when CNA #2 notified the Director of Nursing (DON) of the incident. A record review of the facility fax confirmation of the initial submission notification to SA revealed it was done on 9/12/25 with the incident date of 9/7/25. A record review of the Police Department report revealed it was done 9/12/25.	F0609		