STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255266	A. BUILDING _____ B. WING _____	01/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON COURT	100 BURNHAM ROAD BRANDON, MS 39042

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual survey from 01/02/19 through 01/04/19. During the survey the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements for participation. The SA cited deficiencies at F561, F565, and F645. The facility was licensed for 100 beds and had a census of 75 at the time of survey.	F 000		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social,	F 561		3/4/19

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

Electronically Signed | 03/01/2019

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 561	Continued From page 1 religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility's Resident Care Manual review (used as policy/procedure), the facility failed to ensure resident food preferences were honored for six (6) of nine (9) residents interviewed regarding food choices. Resident #60 and five (5) of eight (8) group participants, which included an unnamed Resident and Residents #5,#8, #37, and #76. Findings Include: A review of the facility's Resident Care Manual, with a revision date of 11/17, revealed the facility would protect and promote the rights of the resident, all residents should have autonomy of choice, resident's individual preferences regarding such things as menus would be elicited and respected by the facility, and efforts would be made to accommodate those wishes. An observation and interview with Resident #60 on 01/02/19 at 12:15 PM, revealed she had an issue with the facility regarding meals. The resident reported she was repeatedly served food items she didn't like after telling staff that she didn't like them repeatedly. The resident's husband was in the room and stated this was true and he had spoken to dietary staff at least seven (7) times regarding the resident being served her dislikes. He stated grits and oatmeal were the biggest problem. The resident stated the staff brought grits or oatmeal almost every day even though she requested to have no grits or oatmeal	F 561	On 3 JAN 2019, Dietary Manager reviewed Residents #60, #5, #8, #37, and #76 meal tickets in order to ensure that applicable food preferences were listed. On 3 JAN 2019, Dietary Manager reviewed seventy-five (75) meal tickets and six (6) out of the seventy-five (75) were identified not to have food preferences appropriately listed. The Dietary Manager and Assistant Dietary Manager corrected this deficient practice in order to honor Resident's preferences by re-printing the six (6) Resident's tickets to reflect their likes and dislikes. On 7 JAN 2019, Administrator provided in-service education to the Dietary Manager regarding Resident input in menu planning and asked that he begin reviewing Resident Council feedback in the aforementioned items addressing Resident Group Response and Resident s Rights deficient practices. The Quality Assurance Committee met on Tuesday, 8 Jan 2019 and reviewed both policies referenced above, Resident s Rights and Resident Council without recommending any changes. The Dietary Manager will review five (5) random meal tickets per day three (3) times per week for four (4) weeks to ensure food preference is listed on meal	

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F 561	Continued From page 2 served to her. The resident stated there were other food items she disliked that the facility would serve to her. The resident stated that many days she was not served what was on the menu. During the interview the resident was served a lunch tray by staff and received red beans and rice, turnip greens, cornbread, and a piece of cake. The tray ticket listed Baked Chicken, Rutabagas, Black eyed Peas, Cornbread, and cake. A review of the tray ticket revealed it did not have resident likes/dislikes listed on it. Resident #60 stated she didn't want red beans and rice, requested peanut butter and jelly sandwiches from staff and received them. In a Resident Council meeting on 01/03/19 at 01:46 PM, five (5) of the eight (8) residents present stated they had told dietary staff their dislikes of food items but it seemed like the information didn't make it to the system, because they continued to be served their dislikes. One (1) resident stated she just doesn't complain and just doesn't eat what she doesn't like. Resident #5 stated she didn't like sausage and biscuits and had those items regularly served to her even after telling staff and sending it back repeatedly. Resident #8 stated he is served biscuits but had requested toast instead of biscuits. Residents think the information is put in the computer, but they still get food dislikes. Resident #37 and #76 didn't like oatmeal but were served oatmeal. Resident #37 stated he would sometimes like to eat breakfast in his room, but he eats in the dining room so that it would be easier to fix his dislikes, because it takes too long on the hallway. An interview on 01/03/19 04:05 PM, with Certified Nurse Assistant (CNA) #1, revealed residents did report frequently that they don't like items on the	F 561	tickets. The Dietary Manager will submit his flowsheets for review by the Quality Assurance Committee on a monthly basis. The Quality Assurance Committee will review the Dietary Manager s reviews once a month for the duration of three (3) months in order to ensure that Resident likes and dislikes are presented on meal tickets and that said preferences are being honored. The Quality Assurance Committee will recommend necessary changes to the Facility Administrator following monthly review. Such review occurred for the month of January's reporting by the Dietary Manager on Tuesday, 5 Feb 2019 with no changes recommended at that time. By submitting the enclosed materials, we are not admitting to the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations.	

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F 561	Continued From page 3	F 561		

meal trays served and many had stated to her that they were served items they put on their dislike list. CNA #1 stated when residents bring it up, she tried to get what they did wanted, and verbally told kitchen staff the person didn't like an item and wanted a different item. CNA #1 stated she did not write the information down anywhere, and would sometimes tell the nurse. She was unsure if the information was recorded anywhere.

An interview on 01/03/19 at approximately 4:10 PM, with Licensed Practical Nurse (LPN) #1, revealed that if a resident reported to her they did not like a food item, she verbally told someone from Dietary. LPN #1 stated residents had told her about being served dislikes and she had passed the information to Dietary for them to go and talk to the resident. LPN #1 stated she saw Dietary Staff (DS) #2 talking to residents frequently regarding meal choices.

An interview on 1/3/19 at 05:23 PM, with the Dietary Manager (DM), revealed his assistant, DS #2, made frequent visits with Resident #60 regarding her food choices and preferences due to the resident's refusal to eat and the facility monitoring her weight. The DM stated that he generally does not talk to the residents regarding their preferences and relied on DS#2 and Nursing Staff to ensure preferences were honored. The DM stated DS#2 would use her I-Pad to record likes and dislikes and they would be on the tray card. The DM pulled up and printed from the computer in his office Resident #60's tray ticket, which listed the likes and dislikes of the resident. When asked if this was what was printed to put on trays when prepared, he stated they print a tray ticket that is to pull from the tray card. The DM printed the tray ticket for Resident #60 for

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F 561	Continued From page 4 01/01/19, and it did not indicate the likes/dislikes and had oatmeal listed to be served, which was a dislike for the resident. The DM stated that there was obviously a problem with the computer system in that the likes/dislikes were not listed on the tray tickets which are used by Dietary Staff to prepare meal trays. He stated he was under the impression that if the resident had a dislike, the system would list it on the tray ticket, or substitute food items automatically on the tray ticket. The DM stated it appeared the regular menu items appeared, despite the resident's dislikes.	F 561		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the	F 565		3/4/19

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F 565	Continued From page 5 facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on Resident Council interview, staff interview, record review, and facility policy review, the facility failed to promptly act on a recommendation of the Resident Council for two (2) of 12 months of Resident Council Minutes reviewed; November/December 2018. Findings Include: A review of the facility's policy titled "Resident Council", with a revision date of 11/17, revealed the facility was to consider the views of the group and act promptly upon recommendations regarding issues of resident life in the facility. A review of Monthly Resident Council Minutes revealed there was a group recommendation to have cheese toast as an option for breakfast in the month of November and December 2018. The November minutes were recorded by designated Activity Staff (AS) #1. The December minutes were recorded by designated AS #2. Although the recommendation was made in November, the December minutes did not indicate any old business and neither monthly	F 565	On 4 JAN 2019, the Dietary Manager updated breakfast menu to include offering cheese toast for breakfast. On 4 JAN 2019, the Dietary Manager reviewed November and December Resident Council minutes indicating that Residents desired to have cheese toast. Out of the fifteen (15) Residents participating in Resident Council both months, 15 out of 15 Residents had the potential to be affected by this deficient practice. On 7 JAN 2019, the Facility's Administrator provided in-service education to all staff on policies and procedures concerning Residents Rights with a latest revision date of November 2017. Additionally, on 7 JAN 2019, the Facility's Administrator provided in-service education to Activities and Social Services on policies concerning the operation of Resident Council with a last revision date of November 2017. The Quality Assurance Committee reviewed both	

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F 565	Continued From page 6 minutes indicated any action taken on the recommendation to have cheese toast as an option for breakfast. In a Resident Council meeting on 01/03/19 at 1:46 PM, the residents in the meeting stated they had requested that they wanted cheese toast as a choice for breakfast, but the facility had not provided the cheese toast, and no one had told them anything or heard back from the request. The residents stated AS #1 and AS #2 were to tell Dietary about the request. An interview on 01/03/19 at 5:00 PM, with AS #1, revealed her acknowledgement of the residents' request for cheese toast to be added as an option for breakfast in the Resident Council meeting in November. AS #1 stated as far as she knew the request has not been acted upon, because some of the residents told her they still hadn't been offered cheese toast. AS #1 stated when residents made a request or brought up problems in group, she typed the issue and gave a typed copy to the departmental staff the issue pertained to. AS #1 stated she typed the request for cheese toast as an option for breakfast and gave it to the Dietary Manager (DM) and the Administrator. She stated she didn't follow up with it after that and it was up to the Department Head of the department it was given to to resolve the issue, along with the Administrator. An interview on 01/03/19 at 5:10 PM, with AS #2, revealed the residents had requested an option of cheese toast being added for breakfast in the December Resident Council meeting. AS #2 stated as far as she knew the residents had not been offered cheese toast at breakfast. AS #2 stated she told the DM of the request. AS #2	F 565	policies referenced above, Residents Rights and Resident Council without recommending any changes during its meeting on Tuesday, 8 JAN 2019. Social Services will facilitate Resident Council alongside Activities and will provide a copy of typed minutes from each meeting to all Facility department heads in order to ensure the timely communication of Resident feedback. The Quality Assurance Committee was pleased with the implementation of a feedback loop to ensure that all departments have the notes necessary to act on the recommendations of our Residents and noted this to be a vital improvement activity during its aforementioned 8 JAN 2019 meeting. The Facility's Administrator will review Resident Council minutes every month in order to ensure that the Facility promptly acts on the feedback shared by Residents present at the meeting. Additionally, the Dietary Manager will review feedback from Resident Council monthly and submit their findings for the inspection of the Administrator. The Quality Assurance Committee will review the Administrator's notes from his own review and those of the Dietary Manager's submission once a month for the duration of three (3) months. January's notes from the Dietary Manager were provided to the Administrator on the 28th of January 2019, and the Administrator approved the recommendations of the Dietary Manager and Registered Dietician Consultant regarding Resident input implementation	

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F 565	Continued From page 7 stated she did not list the recommendation of cheese toast on the old business on the Resident Council minutes because it was still an issue. AS #2 stated she submitted the request to the DM and says she didn't follow up except at the Resident Council meetings. An interview on 1/3/19 at 5:23 PM, with the DM, revealed he generally did not talk to the residents regarding their preferences and relied on DS #2 and nursing staff to ensure preferences were honored. The DM stated he had not been informed of the Resident Council's request to have cheese toast as an option for breakfast and that it would be a very easy request to honor. An interview on 01/04/19 at 12:40 PM, with the facility Administrator, regarding the group recommendation of offering cheese toast as a choice at breakfast and resident food choices being honored, revealed the Administrator was not aware of the Resident Council making a request of having cheese toast as a choice for daily breakfast and had not been informed by Activities staff of the request. The Administrator stated he believed there was a problem with communication that needed to be resolved to ensure resident requests and preferences were honored.	F 565	from the month on the 31st of January 2019. These items were presented to the Quality Assurance Committee's satisfaction during its meeting on Tuesday, 5 February 2019. The Quality Assurance Committee will continue to monitor improvement activities, recommending changes as it deems prudent. By submitting the enclosed materials, we are not admitting to the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:	F 645		3/4/19

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F 645	Continued From page 8 (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a	F 645		

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F 645	Continued From page 9 hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to ensure a Pre Admission Screening (PAS) was completed to reflect a diagnosis of a Major Mental Illness for one (1) of 10 resident PASs reviewed; Resident #6 Findings include: Review of the Facility Policy entitled "Pre-Admission Screening PAS/PASRR (MS Only)", latest Revision: 10/18, revealed, "Anyone applying for admission into a nursing facility must be approved prior to the admission by the Division of Medicaid (DOM) and/or the appropriate Level II authority. The PAS with Level II must be submitted to DOM and approved prior	F 645	The Social Services Director along with the Admissions Coordinator submitted the Change of Status request form for Resident #6 to the State-contracted agency to initiate a Level II review on 3 JAN 2019. The Level II was reviewed by Ascend, and the Level II was completed for Resident #6 on 6 FEB 2019 by the Mississippi State Mental Health Authority. Six (6) of fifteen (15) Residents were identified to have diagnosis, medications, and/or psychological therapy that would indicate the potential need for a Level II and, thus, were at risk because of deficient practice. Nine (9) of the fifteen (15) Residents identified have been	

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F 645	Continued From page 10 to admission to a nursing facility regardless of payment source....When Level I screening on the PAS indicates possible Mental Illness or Intellectual Disability/Developmental Disability and related conditions (RC) the DOM will notify Ascend to review the case. Ascend will determine and notify provider if: 1. Level II evaluation not required. 2. Eligibility for an abbreviated Level II evaluation. 3. Requires onsite Level II evaluation. The Level II evaluation must occur prior to admission and whenever the resident has a significant change in status. .....PAS....The nurse case manager or other facility designee will be responsible for completing the PAS." Review of the PAS for Resident #6, dated 10/1/13, revealed that a Level II PASARR (Pre-Admission Screening and Resident Review) was not performed on admission as indicated by the Electronic Attestation section of the PAS, which indicated that, "A level II evaluation is not indicated at this time". Review of the History and Physical dated 10/1/13, revealed Resident #6 with the diagnosis of Schizophrenia. Review of Resident Diagnosis List revealed the resident also had diagnoses of Anxiety Disorder onset 10/3/16, Major Depressive Disorder onset 10/3/13, and Unspecified Psychosis onset 10/3/13. In a interview with Registered Nurse #1 (RN), on 01/03/19, at 08:23 AM, she stated, "She should have had a Level II because she came in with a psych diagnosis". RN #1 confirmed that Resident #6 did not have a Level II completed on admission to the facility and that it is important for a PAS to be completed accurately to see if they are appropriate for long term placement. She	F 645	excluded from the need for a Level II. The remaining 6 Residents of the original 15 required a Level II screening, and the Facility has initiated applicable significant change requests. An in-service was completed from 3 JAN 2019 by the Facility Administrator concerning relevant policy and procedures entitled Pre-Admission Screening PAS/PASRR (MS ONLY) with a last revision date of October 2018. Admissions Coordinator, Business Office Liaison, Social Services, Nurse Case Manager, and two Assessment Nurses were present and participated in the meeting. The Quality Assurance Committee reviewed the policy titled Pre-Admission Screening PAS/PASRR (MS ONLY) with no recommended changes during its meeting on Tuesday, 8 JAN 2019. Admissions and Minimum Data Sets will be audited by the Director of Nursing and Nurse Case Manager to ensure compliance with facility policy/procedure related to Level II determinations weekly for four (4) weeks and monthly for two (2) months. Findings will be recorded during the weekly transmission meeting and reported using an Admissions/Discharge report for the relevant period to be maintained by the Nurse Case Manager. The Nurse Case Manager will provide a copy of said flowsheet to the Administrator, who will ensure that the admissions detailed on the report have had an appropriate PASRR process	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255266	A. BUILDING _____ B. WING _____	01/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON COURT	100 BURNHAM ROAD BRANDON, MS 39042

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F 645	Continued From page 11 stated that the initial History and Physical (H&P) had a diagnosis of Schizophrenia but it wasn't checked under diagnosis of major mental illness on the PAS. On 01/04/19 at 11:25 AM, during an interview with the Director of Nursing (DON), she reviewed the Pre Admission Screening (PAS) and History and Physical dated 10/1/13, and she confirmed that the PAS was completed inaccurately because in Part B - Level II Referral Criteria, the response to the question 'Person has a diagnosis of a Major Mental Disorder" was answered "No". The DON stated that a Level II PASARR should have been completed on admission due to the diagnoses of Schizophrenia, Anxiety Disorder, Unspecified Psychosis, and Major Depressive Disorder. She confirmed that the facility policy was not followed for Pre Admission Screening.	F 645	completed. The Quality Assurance Committee will evaluate the audits completed by the Director of Nursing, Nurse Case Manager, and/or Administrator monthly for three (3) months and recommend changes as it deems prudent. The corrective action will be completed by 4 March 2019. By submitting the enclosed materials, we are not admitting to the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255266	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/11/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON COURT	**100 BURNHAM ROAD** **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
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 200 SS=D	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 This REQUIREMENT is not met as evidenced by: Based on observations the facility failed to properly maintain illumination of all exit egress signs in accordance to NFPA 101 sections 19.2, 19.2.8 and 7.8. This deficient practice affected three (3) of six (6) exits in the facility on the day of survey. Findings include: On 1/11/19 at 10:45 AM, observation and testing revealed the following exit signs that were not illuminated during inspection of the facility: 1) East Side Exit	K 200	NHA and Maintenance Contract Employee rounded with Life Safety Inspector in order to ensure that Exit signs were properly placed during the course of the survey. On 12 JAN 2019, NHA delivered in-service education to Maintenance Contract Employee regarding the applicable NFPA 101 Standards governing means of egress (Sections 19.2, 19.2.8, and 7.8. Appropriate Exit signage with illumination	3/4/19

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

Electronically Signed | 03/01/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255266	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/11/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON COURT	**100 BURNHAM ROAD** **BRANDON, MS 39042**

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K 200	Continued From page 1 2) Kitchen Exit 3) Central Stair Exit	K 200	was ordered on 12 JAN 2019 so as to allow for the timely replacement of the three signs identified at the Kitchen, East Side, and Central Stair Exit Doors. The NHA will review Weekly Inspection Checklists produced by the Maintenance Tech in order to ensure that exit signage at the 6 exits from the Facility are operating weekly for one month and once a month for three (3) months. By submitting the enclosed materials, we are not admitting to the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255266	A. BUILDING _____ B. WING _____	01/11/2019

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 1/11/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

Electronically Signed | 03/01/2019

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.