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 _____	11/07/2019

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 recertification survey, along with complaint(s), MS #15725, and MS #16140, from 11/4/19 through 11/7/19. The SA substantiated MS #15725 for not allowing a resident to retain personal property and cited F557, related to the complaint. The SA did not substantiate MS 16140 related to dietary/medication, with no deficiency related to the complaint. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited the additional regulatory tags F641, F657, F677, F812 and F880.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to allow residents to have personal property for one (1) of four (4) residents reviewed, Resident #50, as evidenced by staff removing a urinary drainage system from the resident's room and did not replace the urinary drainage system or adequately compensate the resident for the system.	F 557	1. On 11/5/19 the facility deposited $44.58 in resident #50's account as repayment for his urinary drainage system. This was satisfactory for resident #50 2. On 11/7/19, the facility Administrator in-serviced Social Worker and Director of Nursing on Resident's Rights Policy with the latest revision 11/17, Dignity and	12/22/19

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

Electronically Signed | 11/27/2019

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F 557	Continued From page 1 Findings include: Review of the facility's policy, "Theft and Loss", dated September 2013, revealed: It is the policy of this facility to assure each resident's right to retain and use personal possessions as space permits, unless those possessions infringe on the rights, health or safety of other residents. The Social Service Designee, Nurse Supervisor or Administrator will follow up on all reported losses and thefts and document such actions. Review of a written report, received by the State Agency (SA) on 3/1/19, revealed Resident #1 wanted to file a complaint, which involved the facility removing his urinary drainage system and throwing it away. The resident reported the system was bought by his brother for the resident's personal use and the facility should not have taken and destroyed the system. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/11/19, revealed Resident #50's Brief Interview for Mental Status (BIM) score to be 15, which indicated no cognitive impairment. During an interview on 11/04/19 at 10:40 AM, Resident #50 stated the facility gave him two (2) urinals after they took his urine drainage system out of his room. Resident #50 stated they took it out of his room during a state visit. Resident #50 stated that his brother ordered the urine drainage system on line, and could not produce a receipt. Resident #50 stated that he is very happy the facility gave him two (2) urinals to use. During an interview on 11/04/19 at 11:08 AM, the	F 557	Respect Policy with latest revision 11/17, Theft and Loss Policy with latest revision 9/13, and Grievance Policy latest revision 11/17. On 11/18/19 resident council was held and residents were asked if any items had been removed from their rooms without them being reimbursed. Social Worker and Activities Director conducted the meeting. No residents stated that any items had been removed from rooms. 3. The facility Director of Nursing and/or Social Worker will interview 4 cognitive residents weekly for 4 weeks starting 11/18/19. (1) Cognitive resident monthly for (3) months to assure nothing has been removed from the residents room with repayment for item. Any instances will be brought to the Quality Assurance Committee monthly by the Director of Nursing and or Social Worker for any necessary corrective action. 4. This practice could have affected all residents regarding rights to personal property.	

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F 557	Continued From page 2 Director of Nursing (DON) stated Resident #50 did not want to get up during the night to use the restroom, and he had a system, literally a funnel draining into a catheter bag, that his brother had bought for him to use. The DON stated Resident #50 would pour his tea and cokes in the system, as well as his urine from a urinal, into the bag. The DON stated the system was not ordered by the physician and they removed the urine drainage system because it had "stuff growing in it". The DON stated they replaced the system with multiple urinals. The DON stated Resident #50 told her his reason for needing the urine drainage device was because when he urinated, he filled one (1) urinal up too soon. The DON stated the resident added that when he was lying in bed using the urinal, urine would spill out because it was so full. The DON stated they gave him multiple urinals and he hasn't complained since. The DON stated the previous Administrator at the facility handled the issue with Resident #50, and she wasn't sure where it ended. Record review of a facility document titled "petty cash"dated 8/21/19, revealed Resident #50 was given a google play gift card for $20.00. The receipt, offered by the facility, was labeled for Resident #50's activity, but not defined as repayment for the urinal drainage system. During an interview on 11/05/19 at 9:31 AM, Resident #50 stated he did receive a Google play gift card in August, but at the time he guessed he did not realize that was to pay him back for the urinary drainage system. Resident #50 stated when the facility showed him the document on 11/4/19, he remembered the Google card was probably for repayment, but he wasn't sure. Resident #50 stated he just wanted the issue	F 557		

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F 557	Continued From page 3	F 557		

closed and done with. Resident #50 stated the Director of Nursing (DON) told him he couldn't have another urinal drainage system, so he figured he wasn't going to get the system replaced, so he just took the card.

During an interview on 11/05/19 at 9:55 AM, the DON revealed she actually thought that a gift card had been bought earlier than August. The DON stated they had bought Resident #50 several gift cards in the past. The DON stated after they gave him two (2) urinals, Resident #50 said he seemed happy and that was right after the urinal system was taken from his room. The DON stated that she could not say for certain that the gift card, dated 8/21/19, was in replacement for the urinal system, since it wasn't designated especially for that on the receipt. The DON stated the reason they didn't replace the urine system, was that Resident #50 and his brother said it was ordered from Amazon, and it didn't actually come from a medical supply. The DON stated the urine drainage system was an infection control issue, because Resident #50 would place ice, tea and soda in the urinal drainage system as well as urine.

During an interview on 11/05/19 at 10:32 AM, the facility Administrator revealed she had reviewed the grievance log from December 2017 forward, and there was no grievance or investigation on the urinal drainage system noted during that time.

A review of the grievance log dated 12/1/17 through 11/5/19, revealed no grievance recorded on the behalf of Resident #50, nor his roommate, regarding the removal of personal property (urine drainage system) from his room.

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F 557	Continued From page 4	F 557		

A review of facility departmental notes, dated 7/11/18, documented a CNA entered Resident #50's room to find ice chips in the urinary drainage system. No further facility departmental notes were furnished by the facility, regarding issues with the urinal drainage system.

During an interview on 11/05/19 at 10:37 AM, the facility Ombudsman revealed she reported to the DON, when Resident #50 made the complaint about the urinary system was removed from his room. The Ombudsman stated the DON reported they needed a receipt in order to replace the urinary drainage system. The Ombudsman stated Resident #50 reported his brother could not find a receipt. The Ombudsman stated she reported the complaint to the State Agency, since the issue was not resolved, because at the time, Resident #50 wanted the system replaced.

During an interview on 11/5/19 at 2:11 PM, the Administrator stated she found a picture of a similar urine drainage system with a value of $44.58, and showed it to Resident #50, who agreed the item was similar to the urine drainage system taken from his room earlier in the year. The Administrator stated Resident #50 wanted the money for the item instead of the facility replacing the item, so they deposited $44.58 in his facility account. A receipt dated 11/5/19, was provided for the $44.58 deposit.

During an interview on 11/05/19 at 2:50 PM, the DON revealed they never intended to replace the urine drainage system, once it was removed from the room, because it was an infection control issue, as well as a fall hazard, related to spillage of urine on the floor.

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F 641	Continued From page 5	F 641		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to perform an accurate Minimum Data Set (MDS) Assessments on two (2) of 25 MDS Assessments reviewed, Resident #73 for discharge location, and Resident #19 for an indwelling Foley Catheter. Findings include: Review of the facility's "Resident Minimum Data Set (MDS) Assessment" policy, revised 09/19, revealed an assessment will be completed on each resident utilizing the MDS. The reason for assessment, schedule, and timeframes will be according to the guidance of the Resident Assessment Instrument (RAI) Manual. The Registered Nurse is responsible for verifying the completion of the assessment. Any Healthcare professional that completes a portion of the assessment must sign and certify the accuracy of the portion of the assessment they have completed. Resident #19 Review of the MDS, with an Assessment Reference Date (ARD) of 8/12/19, revealed the section, which applied to an indwelling catheter, was not checked for Resident #19.	F 641	1. On 11/6/19 the facility's Director of Nursing in-serviced (2) Assessment Nurses and (1) Nurse Case Manager on Residents MDS Assessment Policy with the latest revision 9/19 and Sections H0100 (Appliances) and A2100 (Discharge Status) from the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 manual and the importance of coding correctly. On 11/9/19, Resident #19 Quarterly Minimum Set was modified and facility Nurse corrected Section H. Resident #73 Discharge Minimum Data Set was modified and corrected by the facility's Assessment Nurse on 11/11/19. These corrections were needed for residents #19 and #73 due to they did not have catheter coded on MDS. 2. The facility administrator and Director of Nursing will review five(5) Minimum Data Sets weekly, beginning 11/11/19 before facility transmits to ensure that Section H0100(Appliances) and Section A2100(Discharge Status) were coded correctly. The Quality Assurance Committee evaluate audits completed by the Administrator and Director of Nursing monthly for three months and make recommendations and changes to ensure	12/22/19

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F 641	Continued From page 6 On 11/05/19 at 9:51 AM, an observation of Resident #19 revealed the resident had a Foley Catheter. Review of Resident #19's Physician's orders, dated 7/12/19, revealed the resident had orders for a Foley Catheter for retention of urine. During an interview on 11/05/19 at 10:00 AM, Resident #19 revealed he's had a Foley Catheter since July 2019. During an interview on 11/05/19 at 3:57 PM, Registered Nurse #1/MDS Nurse, revealed the MDS for Resident #19 was coded incorrectly; the resident has a Foley catheter. Resident #73 Review of the MDS, with an ARD of 9/24/2019, revealed the MDS coded the resident was discharged to the hospital. Review of the face sheet and discharge summary, dated 09/24/19, revealed Resident #73 was discharged home. Review of the physician orders, dated 09/17/19, revealed Resident #73 was discharged home with medications, home health physical therapy, and occupational therapy, on 9/24/19. On 11/06/19 at 2:00 PM, an interview with RN #1/MDS Coordinator, revealed Resident #73 was discharged home. RN #1 stated the MDS was coded incorrectly, that the resident was hospitalized; the MDS should have been coded the resident was discharged home.	F 641	compliance. 3.On 11/13/19 the facility's Nurse Case Manager audited Minimum Data Sets completed from the last Quarter and determined (1) out of 92 Minimum Data Sets reviewed needed to be corrected. This one(1) Minimum Data Set was corrected by the facility's Assessment Nurse on 11/13/19. On 11/13/19 the facility's Nurse Case Manager audited Minimum Data Sets Discharged from last quarter and none (0) out of 76 needed to be corrected. 4. All residents could have been potentially affected by this practice.	

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F 657	Continued From page 7	F 657		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to revise the care plan, related to a Dementia Diagnosis, for one (1) of 25 Comprehensive Care Plans reviewed, for Resident #16. Findings include:	F 657	1. On 11/7/19, Resident #16 Comprehensive Care plan was revised to address diagnosis of Dementia by the facility Nurse Case Manager. 2. On 11/7/19, the facility Administrator in-serviced (1)one Social Worker on Care	12/22/19

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F 657	Continued From page 8 Review of the facility's policy, "Care Plan Process", revised 8/2017, revealed following the decision to address a triggered condition on the care plan, key staff or the Interdisciplinary Team should subsequently review and revise the current care plan, as needed. Review of Resident #16's current Comprehensive Care Plan, through the next review date of 11/20/19, revealed a Dementia/Alzheimer's diagnosis was not addressed in the care plan. Review of a "Psychiatric Evaluation Report", dated 4/14/19, revealed a diagnoses of Major neuro cognitive disorder of Alzheimer mixed type. Review of Resident #16's diagnoses, in the current November 2019 Physician Orders, revealed a diagnosis of unspecified Dementia with behavioral disturbance. Review of Resident #16's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/12/19, revealed an active Diagnosis of Non-Alzheimer's Dementia. Review of Resident #16's MDS, with ARD date of 5/17/19, revealed a Care Area Assessment (CAA) Summary of Cognitive Loss/dementia, which triggered and directed staff to continue to care plan. In an interview on 11/07/19 at 9:15 AM, Registered Nurse (RN) #1/MDS Nurse, confirmed Resident #16 was diagnosed with Dementia in February of 2019. RN #1 stated it was the responsibility of the Social Services staff, who was no longer working at the facility, to complete	F 657	Plan Process with latest revision 08/17. 3. On 11/13/19, the facility's Social Worker audited 82 Comprehensive Care Plans and determined (0)zero out of 82 Comprehensive Care Plans need to be revised to reflect diagnosis of Dementia. 4. The facility's Social Worker will review three(3) Comprehensive Care Plans Weekly for four(4) weeks then one (1) per week for (4) weeks beginning on 11/13/19. The Quality Assurance Committee will evaluate the audits completed by Social Worker monthly for three months and make recommendations and changes to ensure compliance.	

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F 657	Continued From page 9 the cognitive section of the MDS, and to complete the care plan after the assessment. RN #1 stated she did not know why the care plan wasn't developed for Dementia at the time of the MDS, with an ARD of 5/17/19, but since the updates in October, the nurses would now be responsible, and the care plan for Dementia would be addressed. RN #1 stated, per facility policy, Resident #16 should have a care plan for Dementia, according to the CAA summary on the MDS, to proceed to care plan.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to assist residents with Activities of Daily Living (ADL), related to grooming/shaving, for two (2) of 25 residents observed, Resident #278, and Resident #29. Findings include: Review of the "Quality of Care" policy, revised 4/2019, revealed: Each resident shall receive optimal care to attain and/or maintain the highest possible mental and physical functional status as determined by the comprehensive assessment and person-centered plan of care. Bathing: At the time of the bath, all residents shall also receive, if applicable, a shave.	F 677	1. On 11/5/19, Residents #29 was shaved by Certified Nursing Assistant. On 11/6/19 resident #278 was shaved by Certified Nursing Assistant. 2. On 11/6/19, the facility's Director of Nursing and Registered Nurse Supervisor assessed 88 out of 88 residents and determined zero (0) out of 88 needed to be shaved. 3. On 11/8/19, the facility's Staff Development Nurse in-serviced Certified Nursing Assistants on Quality of Care Policy with the latest revision 04/19 and Shaving Policy with latest revision 10/17. 4. The facility's Director and/or Registered	12/22/19

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F 677	Continued From page 10 Review of the "Shaving Policy", with a revision date of 11/2017, revealed all male residents will be shaved daily. Residents on Coumadin or other anti-coagulation meds will be shaved with an electric razor/shaver. Resident #29: On 11/04/19 at 11:00 AM, an observation and interview, revealed Resident #29 had hair on her chin. Resident #29 stated she does not like hair on her chin and stated her husband used to shave the hair on her chin. Observation on 11/05/19 at 10:12 AM, revealed Resident # 29 with hair on her chin. She stated she was just given her bath early this morning, and no one shaved her chin. On 11/05/19 at 3:09 PM, an Interview with Director of Nursing (DON), regarding Resident #29's grooming, revealed someone should assist the resident with her facial hair; she will make sure it gets done today. Review of the Minimum Data Sheet (MDS), with an Assessment Reference Date of 9/6/19, revealed Resident #29 required assistance of two (2) persons for ADLs. The resident's Brief Interview for Mental Status (BIMS) score was 10, which indicated moderate cognitive impairment. Resident #278 Observation on 11/04/2019 at 11:00 AM, revealed Resident #278 sitting in the therapy room, unshaved. Observation on 11/05/19 at 10:39 AM, revealed Resident #278 sitting in his room in a wheelchair, unshaved.	F 677	Nurse Supervisor will assess (3) Residents Daily for (1) week, then three (3) residents weekly for (4) weeks and (3) residents monthly for (3) months to ensure that they have been shaved beginning on 11/11/19. The Quality Assurance Committee will evaluate the assessments completed by Director of Nursing and/or Registered Nurse Supervisor monthly for thee(3)months and make recommendations and changes to ensure compliance. 5. All residents could have been affected that could require ADL care for shaving	

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F 677	Continued From page 11 During an interview, on 11/05/19 at 10:40 AM, Resident #278 stated he preferred to be shaved. The Resident stated that he shaved every two (2)-three (3) days when he was at home. Resident #278 could not recall if staff asked him about shaving. Review of Resident #278's most recent Brief Interview for Mental Status (BIMS) score was 11, which indicated moderate cognitive impairment. On 11/06/19 at 10:47 AM, observation revealed Resident #278 sitting in therapy, in pajamas, unshaved. During an interview on 11/06/2019 around 11:00 AM, Licensed Practical Nurse (LPN) #1 revealed residents are assisted with ADLs on a daily basis. LPN #1 stated Resident #278 was admitted to the facility for Rehabilitation and had muscle weakness. On 11/06/19 at 11:20 AM, an interview with the Director of Nursing (DON) revealed the resident gets a shower every other day and staff should offer shaving at that time. On 11/06/19 at 2:00 PM, an interview with the DON revealed the facility had purchased an electric razor, so Resident #278 could be shaved, since he was on anti-coagulation medicine and could not be shaved with disposable razors. She stated the resident's family had shaved him in the past. and she was waiting on family to come in to shave him. She stated they will shave him today.	F 677		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		12/22/19

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	255266	A. BUILDING _____ B. WING _____	11/07/2019

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

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F 812	Continued From page 12 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to prevent cross contamination of food while dining, for one (1) of three (3) dining observations, which affected Resident #66. This was evidenced by a Certified Nursing Assistance touching the resident's food with her bare hands, and feeding the resident the food. Findings include: Review of the facility's "Feeding a Dependent Resident" policy, with a revision date of 10/2017, revealed to allow the resident to hold finger foods as able. The policy also documented gloves were part of the supplies to be utilized during the process of feeding a resident. During the dining observation on 11/04/19 at	F 812	1. On 11/6/19, Resident #66 was assessed by facility Director of Nursing on 11/06/19 at 4:30pm with no adverse effects noted. 2. On 11/7/19, the facility's Director of Nursing and Registered Nurse Supervisor observed at meal time with no cross contamination of food while dining observed at 11:45am. 3. On 11/8/19, the facility's Staff Development Nurse in-serviced all Certified Nursing Assistants on Feeding a Dependent Resident Policy with latest revision 10/17. This in-service included necessary supplies to include sanitizer for hand hygiene, food tray, and clothing protector. The proper technique for	

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F 812	Continued From page 13 12:23 PM, in the dining room by the kitchen, Certified Nursing Assistant (CNA) #1 picked up a piece of fried chicken, a drum stick, with her bare hands, to assist Resident #66 to eat. CNA #1 held the drum stick with her bare hands to the resident's mouth, so the resident could take a bite. Resident #66 took the drum stick and attempted to hold it to eat. The resident dropped the chicken in his lap, which had a clothing protector in place, and the CNA picked up the chicken again, with her bare hands, and attempted to feed the resident. The resident dropped the chicken again in his lap, and CNA #1 then picked the chicken up with a napkin, and cut the meat off the bone with a knife. During an interview on 11/06/19 at 4:28 PM, the Director of Nursing (DON) stated staff touching food with bare hands was not the facility policy and it could contaminate the food. The DON stated she reviewed the video of the dining observation and she confirmed CNA #1 did touch the drum stick with her bare hands to feed the resident.	F 812	feeding a dependent resident to include positioning and safe guarding and safe guarding against cross contamination. 4. The facility's Director of Nursing and/or Registered Nurse Supervisor will observe one of the three dinning rooms daily for (1) week, then weekly for (4) weeks, and monthly for (3) months to ensure that no cross contamination of food while dining occurs beginning 11/11/19. The Quality Assurance Committee will evaluate the assessments completed by Director of Nursing and/or Registered Nurse Supervisor monthly for three months and make recommendations and changes to ensure compliance.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		12/22/19

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F 880	Continued From page 14 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed	F 880		

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F 880	Continued From page 15 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to prevent cross contamination during medication pass, related to the use of a pulse oximeter, for one (1) of four (4) Nurses observed. This was evidenced by the nurse carrying the pulse oximeter in her pocket, an unsanitary location, prior to use. Findings include: Review of the Infection Control Policy for General Cleaning and Maintenance of Equipment, revealed: It is the policy of this facility that all resident care equipment will be cleaned and decontaminated after use, and will be prepared for reuse for the same or another resident. Equipment will be cleaned and decontaminated, according to manufacturer's recommendation. Procedure for General Cleaning and Maintenance of Equipment:	F 880	1. On 11/5/19 at 10:00am resident #4 was assessed by the facility Director of Nursing with no adverse effect noted. Resident assessed due to pulse ox not being sanitized prior to use. 2. On 11/5/19, the facility's Director of Nursing and Registered Nurse Supervisor observed four(4) out of (4)nurses during medication pass with no cross contamination observed related to the use of pulse oximeter. 3. On 11/5/19, the facility's Director of Nursing in-serviced Licensed Practical nurses and Registered Nurses on Infection Control Policy for General Cleaning and Maintenance of Equipment. 4. The facility's Director of Nursing and or Registered Nurse Supervisor beginning 11/11/19 will observe one Licensed Practical Nurse during medication Pass	

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F 880	Continued From page 16 1. All equipment and supplies will be cleaned and decontaminated immediately after use. 2. Equipment is then decontaminated with an EPA-approved and facility-approved disinfectant. 3. Equipment is resupplied, covered, and returned to storage or resident area, ready for reuse only after decontamination. The Disinfectant facility uses is Super-Sani-Cloth. Observation on 11/05/19 at 8:20 AM, revealed License Practical Nurse (LPN) #1 removed the Pulse Oximeter from her nursing uniform pocket, then performed a pulse oximeter reading on Resident #4. LPN #1 placed the pulse oximeter in the Medication Cart top drawer, without cleaning/disinfecting the pulse oximeter before, or after use, on Resident #4. During an interview, on 11/05/19 at 8:32 AM, LPN #1 stated she should not have placed the pulse oximeter in her pocket, and she should have cleaned the pulse oximeter prior to placing it in the medication cart drawer, for sanitary reasons. During an interview, on 11/05/19 at 9:15 AM, the Director of Nursing (DON) was informed of LPN #1's use of the pulse oximeter, that she pulled the Pulse Oximeter from her nursing uniform pocket, placed it on the resident, then placed it back in the medication cart drawer, without cleaning/disinfecting the oximeter. The DON stated LPN #1 should not have placed the pulse oximeter in her pocket. She stated the pulse oximeter should have been cleaned with sanitized wipes, due to infection control issues.	F 880	three(3) times for (1)one week, then (1)one time for four(4) weeks and one (1) time per month for three (3) months to ensure that no cross contamination related to use of pulse oximeter occurs. The Quality Assurance Committee will evaluate the assessments completed by the facility Director of Nursing and/or Staff Development Nurse monthly for three months and make recommendations and changes to ensure compliance. 5. All residents requiring the use of facility equipment could have been affected by this practice.	

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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 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to properly inspect fire doors as required by S&C Letter 1738. This condition affected four (4) of six (6) smoke compartments all 93 residents in the facility on the day of survey Findings include: On November 5, 2019 at 11:40 AM, observation revealed four (4) fire doors in the facility. The facility was unable to produce documentation of an annual fire door inspection. The facility said they were unaware of the requirement for fire door inspections. The building is a 2-story building and the fire doors were located at the stairwells on each end of the building.	K 211	1. On 11/27/19 Precision Door was contacted to inspect Fire Doors. 2. On 11/29/19 Precision Door came and inspected fire doors both visually and operational. The technicians documented fire door serial numbers and checked functional status of door closure. Fire doors passed this inspection. 3. All facility fire doors will be inspected annually by certified vendor as required going forward. 4. 93 out of 93 residents had the potential to be negatively effected by this deficit practice.	12/21/19

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

Electronically Signed | 11/29/2019

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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K 211	Continued From page 1	K 211	5. Administrator in-serviced maintenance director on 11/14/19 on the requirement to have fire doors inspected annually by a certified vendor. Administrator will monitor and ensure inspections are conducted annually. 6. Administrator or Maintenance Director will visually inspect fire doors weekly for(4)weeks and monthly for(3) months. Any adverse findings will be reported to certified vendor for corrective action and to the facility's Quality Assurance Committee for any facility corrective action.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms	K 321		12/21/19

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K 321	Continued From page 2 b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to properly protect hazardous areas in accordance to NFPA 101 section 19.3.2.1. This deficiency affected four (4) of six (6) smoke compartments and 28 of 93 residents in the facility on the day of survey Findings include: During the building inspection on November 5, 2019 between 1:40 PM and 2:40 PM, observation revealed deficiencies in the following hazardous areas of the facility: 1) Unsealed openings and penetrations in the ceiling and walls of the Clean Linen of the facility 2) Unsealed openings and penetrations in the ceilings of the Central Supply Room, HVAC Closet near Therapy Area and the Sever Room of the facility. 3) The doors to the Bio-Haz Room, Kitchen Door, Housekeeping and Hopper Room would not close to positive latching position. These hazardous areas were incapable of resisting the passage of smoke throughout the facility.	K 321	On 11/11/19 openings and penetrations in the following areas were sealed by outside contractor. Openings in the ceiling of Central Supply Closet, HVAC closet near Therapy Room, clean linen celling, and the Server Room have been repaired by outside contractor on 11/11/19.Housekeeping door was replaced on 11/13/19 by maintenance director. Door at kitchen, Hooper Room, and Bio-Hazard room were adjusted to ensure proper closing action (positive latching) on 11/13/19 by maintenance director. 93 out of 93 residents could have been effected by deficit practice. Administrator in-serviced maintenance director on 11/12/19 regarding proper seals in all areas of the facility to ensure all doors are in good repair and close properly with proper hardware. maintenance will monitor by completing weekly facility rounds for (4) weeks and then weekly for (2) months. Maintenance Director or Administrator will	

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K 321	Continued From page 3	K 321	monitor all areas to assure proper seals are in place, that facility doors are in good condition, and that they operate properly with the proper hardware weekly for (4)weeks and monthly for (3) months and thereafter. Any deficits identified will be reported to the Quality Assurance Committee for corrective or disciplinary actions deemed necessary.	
K 347 SS=D	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to properly protect corridors as per NFPA 101 section 19.3.6.1. This deficiency affected one (1) of four (4) smoke compartments and 17 of 93 residents in the facility on the day of survey. Findings include: On November 5, 2019, 2019 at 11:45 AM, observation revealed no a hard-wired smoke detector protecting the Copy Room and Locker Area of the facility. The Copy Room and Locker Area were open to the main corridor of the facility.	K 347	On 11/6/19 Electronic Controls Installed (2) smoke detectors. (1) detector by copier room and (1) in locker area. These detectors were tested to ensure proper working order.. 93 out of 93 resident could have been negatively affected by this deficit practice. Detectors will be inspected weekly for (4) weeks and monthly for (3)months by maintenance and annually by certified vendor. Administrator will monitor to ensure maintenance is completed. Any deficit practices identified by maintenance or Administrator will be reported to the Quality Assurance Committee for any corrective or	12/21/19

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K 347	Continued From page 4	K 347	disciplinary action.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to provide a supervised automatic sprinkler system with complete coverage for all portions of the building as required by NFPA 101 section 19.3.5.1. This deficiency affected two (2) of six (6) smoke compartments and 47 of 93 residents in the facility on the day of survey. Findings include: On November 5, 2019 at 1:05 PM, observation revealed no fire sprinkler protection in the 1st	K 351	1. In the Restorative closet located on the 1st floor, on 11/14/19 the wall was lowered by 12 inches to ensure proper sprinkler protection in this area by outside contractor. The clean linen area located on the 2nd floor wall was lowered by 12 inches to ensure sprinkler can provide adequate protection for this area. 2. Maintenance will monitor for proper sprinkler exposure weekly for(4) weeks then monthly for(3) months. Certified vendor will inspect annually.	12/21/19

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K 351	Continued From page 5 Floor Restorative Closet and 2nd Floor Clean Linen Area of the facility.	K 351	3. 93 out of 93 residents have the potential to be effected by this deficit practice. 4. Administrator in-serviced maintenance director on 11/12/19 regarding ensuring that no sprinkler is obstructed by physical design or removable objects that would prevent sprinkler from providing adequate fire protection. Any adverse findings will be reported to the Quality Assurance Committee and Safety Committee for corrective action.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to properly document fire drills as per NFPA 10119.7.1.2. This deficiency affected all 93 residents in the facility on the day of survey Findings include:	K 712	1. On 11/14/19 maintenance supervisor was in-serviced on the appropriate documentation to be provided for fire drill. The frequency at which these drill should be conducted and Fire Drill policy latest revision 04/06.	12/21/19

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 _____	**11/05/2019**

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 712	Continued From page 6 During document review on November 5, 2019 at 12:20 PM, the facility could not provide documentation of a fire drills conducted on any work shifts during the last calendar year of 2019.	K 712	2. Administrator will monitor monthly for completeness and timeliness that drills are held monthly on rotating shifts for (3)months. 3. 93 out of 93 have been potentially negatively effected by the deficit practice. 4.Any adverse findings will be reported by Maintenance Director to the Quality Assurance Committee for corrective action.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the	K 918		12/21/19

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	255266	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/05/2019**

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K 918	Continued From page 7 components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to properly inspect the emergency generator as per NFPA 110 section 8.4.1. This deficiency affected all 93 residents in the facility at the time of survey. Findings include: During document review on November 5, 2019 at 12:25 PM, the facility could not provide documentation showing the weekly inspections and monthly load tests for the generator during the last calendar year of 2019.	K 918	1. On 11/14/19 maintenance supervisor was in-serviced on Generator Testing policy latest revision 04/06. This in-service included the correct way to perform generator testing weekly and monthly. 2. Administrator will monitor weekly test for (4) weeks then monthly for (3)months. 3. 93 out of 93 resident could have been negatively effected by this deficit practice. 4. Any adverse findings will be reported by maintenance director to a certified vendor, the Safety Committee, and Quality Assurance Committee for corrective actions	

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	255266	A. BUILDING _____ B. WING _____	11/05/2019

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E 000	Initial Comments ********** Survey conducted on 11/05/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

Electronically Signed | 11/29/2019

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.