

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 61CM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/10/2020
NAME OF PROVIDER OR SUPPLIER BRANDON NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 355 CROSSGATE BLVD BRANDON, MS 39042		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an abbreviated/partial survey investigating MS CI #16528 and MS CI #16498 beginning 1/9/20 through 1/10/20. The areas reviewed for investigation included, sexual abuse of Resident #1 and no hot water in the shower. The SA did not substantiate the complaint for sexual abuse or for the water being cold in the showers and no deficiencies were cited. During the survey, the SA determined the facility was in substantial compliance with requirements of participation in Medicare and Medicaid. At the time of the complaint survey, the facility had census of 229.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE