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 _____	11/21/2024

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
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 11/18/24 through 11/21/24. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F585 and F880. The facility had a census of 83 and was licensed for 106 beds.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the	F 585		1/3/25

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

Electronically Signed | 12/06/2024

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 _____	11/21/2024

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
F 585	Continued From page 1	F 585		

provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source,

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 _____	11/21/2024

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
F 585	Continued From page 2 and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility policy reviews, the facility failed to ensure grievances regarding rude staff were resolved in a timely manner for five (5) of the 19 sampled residents. (Residents #3, #8, #9, #45 and #55) Findings included: A review of the facility's policy titled "Grievances-Residents," revised 05/24, revealed, "All residents are to be encouraged and assisted	F 585	a. On 11/21/2024 residents #3, #8, #9, #45, and #55 were assessed by the Director of Nursing on any adverse effects related to how the facility failed to appropriately resolve grievances. There were no adverse effects noted. b. All residents who file grievances have the potential to be affected by this deficient practice.	

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 _____	11/21/2024

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
F 585	Continued From page 3 (if necessary) in filing grievances to include those with respect to care and treatment, the behavior of staff and other residents, and other concerns regarding their facility stay, in the event that they have a need to make a concern known ... The facility shall make prompt efforts to resolve the grievances ..." A review of the facility's policy titled "Resident Rights," dated 12/23, revealed, "Every resident in this facility has the right to ... 12. Be treated courteously, fairly, and with the fullest measure of dignity ..." On 11/20/2024 at 2:00 PM, during an interview with Resident Council members, several residents (Residents #3, #8, #9, #45, and #55) expressed concerns about rudeness from staff working the 11:00 AM to 7:00 PM shift. Residents reported that Certified Nurse Aides (CNAs) consistently displayed rude and dismissive behavior, often entering rooms with negative attitudes and phrases such as, "What do you want?" or "Didn't someone help you earlier?" Residents noted instances where CNAs turned off call lights without assisting or providing explanations. The Resident Council concluded that the issue had not been adequately resolved despite multiple complaints. On 11/21/2024 at 10:23 AM, during a follow-up interview, Resident #8 recounted that CNAs working the 11:00 AM to 7:00 PM shift frequently displayed rude behavior. She described an incident where she requested assistance pulling up her brief due to hand pain and muscle weakness. The CNA responded rudely, questioning, "Can't you do that yourself?" before reluctantly assisting her. Resident #8 expressed	F 585	c. On 11/21/2024 an audit was conducted by the Facility Administrator and the Social Services Director to review and resolve any unresolved grievances. The Staffing Coordinator was in-serviced by the Director of Nursing on 11/22/2024 on training duties to ensure that all staff, including 11pm-7am Nurses and CNAs, are in-serviced on Resident's Rights. The Facility Administrator and Social Services Director will ensure that grievances are resolved in a timely manner, and Resident's Rights are not violated. d. Beginning on 12/04/2024 the Facility Administrator and Social Services Director will conduct Resident Council meetings 1 time a week for 4 weeks, then bi-weekly for 4 weeks, then monthly unless additional meetings are needed. Areas of concern will be brought to the Quality Assessment and Improvement Committee for review. The Quality Assessment and Improvement Committee will convene on 01/03/2025, and meet once a month for 3 months to discuss further recommendations as needed. Additional training and/or disciplinary action will be considered as warranted.	

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 _____	11/21/2024

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
F 585	Continued From page 4	F 585		

disappointment over the recurring rudeness and stated this issue had persisted for some time.

On 11/21/2024 at 10:46 AM, during an interview, Resident #45 shared negative experiences with CNAs on the 11:00 PM to 7:00 AM shift. She stated that CNAs assigned to her usually entered with short tempers, expressing irritation at having to assist her.

On 11/21/2024 at 11:00 AM, during an interview, the Social Services Director confirmed conducting Resident Council meetings and acknowledged persistent complaints about rude CNAs on the overnight shift. She noted that residents reported CNAs entering rooms with negative attitudes, turning off call lights without helping, and being unwilling to assist. These grievances were forwarded to the Staff Development Nurse, and copies were sent to the Administrator.

On 11/21/2024 at 11:14 AM, during an interview, the Staff Development Nurse confirmed receiving the grievances and acknowledged the issue of CNA rudeness on the night shift. She explained that staff in-service training is typically used to address such concerns and disapproved of the CNAs' behavior, stating it could make residents feel uncomfortable and disrespected.

A record review of the in-service sign-in sheets provided by the Staff Development Nurse revealed that in-services were conducted on 03/28/24, 05/29/24, and 07/25/24. All of these in-service sign-in sheets revealed that the attitude and rude behavior that had been reported was addressed. However, review of the sign-in sheets did not have signatures of any of the CNAs that

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 _____	11/21/2024

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
F 585	Continued From page 5	F 585		

work the 11:00 PM to 7:00 AM shifts.

On 11/21/2024 at 11:36 AM, during an interview, the Administrator confirmed that all grievances are discussed during morning meetings, with a goal of resolving them within forty-eight (48) hours. She acknowledged the recurring complaints regarding rude CNAs on the 11:00 AM to 7:00 PM shift, which had been raised in previous Resident Council meetings.

A record review of the corrective action plan for grievances revealed that concerns regarding rude CNAs on the 11:00 PM to 7:00 AM shift were documented on 05/22/2024 and 07/16/2024.

A record review of Resident #3's "Admission Record" revealed the facility admitted the resident on 06/17/2021. The resident had diagnoses that included Generalized Osteoarthritis and Hemiplegia and Hemiparesis affecting the left non-dominant side.

A record review of Resident #3's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/03/2024, revealed a Brief Interview for Mental Status (BIMS) score of (15), which indicated the resident was cognitively intact.

A record review of Resident #8's "Admission Record" revealed the facility admitted the resident on 02/0/2008. The resident had diagnoses that included Generalized Muscle Weakness and Unsteadiness of Feet.

A record review of Resident #8's Quarterly MDS with an ARD of 09/09/2024, revealed a BIMS score of (14), which indicated the resident was

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 _____	11/21/2024

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
F 585	Continued From page 6 cognitively intact. A record review of Resident #9's "Admission Record" revealed the facility admitted the resident on 06/20/2024. The resident had diagnoses that included Parkinson's Disease with Dyskinesia and Muscle Weakness. A record review of Resident #9's Quarterly MDS with an ARD of 09/23/2024, revealed a BIMS score of (14), which indicated the resident was cognitively intact. A record review of Resident #45's "Admission Record" revealed the facility admitted the resident on 03/16/2021. The resident had diagnoses that included Unspecified Osteoarthritis and Muscle Weakness. A record review of Resident #45's Quarterly MDS with an ARD of 08/29/2024, revealed a BIMS score of (14), which indicated the resident was cognitively intact. A record review of Resident #55's "Admission Record" revealed the facility admitted the resident on 07/26/2023. The resident had diagnoses that included Morbid Obesity and Gout. A record review of Resident #55's Quarterly MDS with an ARD of 09/06/2024, revealed a BIMS score of (14), which indicated the resident was cognitively intact.	F 585		
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	F 880		1/3/25

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 _____	11/21/2024

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
F 880	Continued From page 7	F 880		

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 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 §483.71 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

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 _____	11/21/2024

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
F 880	Continued From page 8 (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 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, interviews, record review, and facility policy review, the facility failed to prevent the possible spread of infection during Percutaneous Endoscopic Gastrostomy (PEG) tube care for one (1) of three (3) residents with PEG tubes. (Resident #57) Findings included: A review of the facility's policy titled "Hand Hygiene," revised 01/24, revealed, "Purpose * To cleanse hands to prevent transmission of infection or other conditions * To provide clean, health environment for residents, staff and	F 880	a. On 11/20/2024 resident #7 was assessed by the Director of Nursing on any adverse effects related to how the facility failed to ensure infection control measures related to hand hygiene were met during a Percutaneous Endoscopic Gastrostomy (PEG) insertion site care. There were no adverse effects noted. b. Three of eighty six residents that have a Percutaneous Endoscopic Gastrostomy (PEG) insertion site have the potential to be affected by this deficient practice.	

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 _____	11/21/2024

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
F 880	Continued From page 9 visitors ... Indications for Hand Washing... 4. Before and after applying gloves ..." On 11/20/2024 at 9:30 AM, during an observation of PEG tube care performed by Registered Nurse (RN)/Wound Care Nurse #1, after beginning care, she removed the dressing from the PEG tube site, removed her gloves, and applied clean gloves without performing hand hygiene. She cleaned the wound, removed her gloves, and applied another set of clean gloves, again without performing hand hygiene. She dried the wound and removed her gloves. Hand hygiene was not completed during the entire procedure. On 11/20/2024 at 9:40 AM, during an interview, RN #1 confirmed that she forgot to perform hand hygiene between glove changes. She acknowledged contaminating clean gloves by not washing her hands between changes and stated this could potentially result in an infection for the resident. On 11/20/2024 at 11:22 AM, during an interview, the Director of Nurses (DON) stated that RN#1 should have performed hand hygiene after each glove change. She emphasized that the resident could develop an infection at the PEG site due to this oversight and stated her expectation that all staff perform hand hygiene consistently. On 11/20/2024 at 11:34 AM, during an interview, Licensed Practical Nurse (LPN) #1 /Infection Preventionist (IP) confirmed that the RN #1 should have performed hand hygiene between glove changes. She stated that failing to do so constitutes cross-contamination and increases the risk of infection for Resident #57. She noted that she conducts hand hygiene in-services	F 880	c. On 11/20/2024 the Director of Nursing completed a one-on-one education with Wound Care Registered Nurse on Hand Hygiene. The Director of Nursing and Infection Prevention Nurse also initiated an in-service with Licensed Practical Nurses and Registered Nurses regarding Hand Hygiene on 11/20/2024 and was completed on 11/25/2024. d. An initial Quality Assurance Committee Meeting was conducted on 12/03/2024 to discuss findings from annual health survey in reference to Infection Prevention and Control to prevent the possible spread of infection during Percutaneous Endoscopic Gastrostomy (PEG) tube care. Beginning on 11/22/2024 the Director of Nursing and/or Registered Nurse Supervisor will observe wound care with emphasis on hand hygiene, before and after treatment, and in between glove changes 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then 1 time a week for 4 weeks. The Director of Nursing and/or RN Supervisor will report any issues identified to the Quality Assessment and Improvement Committee. The Quality Assessment and Improvement Committee will convene on 01/03/2025, and meet once a month for 3 months to discuss further recommendations as needed.	

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 _____	11/21/2024

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
F 880	Continued From page 10	F 880		

quarterly and as needed.

A record review of the "Admission Record" revealed Resident #57 was admitted by the facility on 11/02/22. The resident had diagnoses that included Dysphagia, Pharyngoesophageal Phase.

A record review of Resident #57's Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/23/2024, revealed a Brief Interview for Mental Status (BIMS) score of (99), indicating that the resident could not complete the interview. Further review of the MDS revealed staff assessment of mental status indicated that Resident #57 had severe cognitive impairment. Review of Section K revealed the resident had a PEG tube.

A record review of the in-service dated 9/25/2024, revealed the signature of RN #1 on the sign-in sheet for training related to Infection Control.