

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/28/2026	
NAME OF PROVIDER OR SUPPLIER BRANDON COURT				STREET ADDRESS, CITY, STATE, ZIP CODE 100 BURNHAM ROAD , BRANDON, Mississippi, 39042			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
M0000	Initial Comments		M0000				
	The State agency (SA) conducted a Compliant Investigation (CI) on 5/28/26 to investigate a Facility Reported Incident (FRI) incident #2959557. During the investigation the SA determined the facility to not be in compliance for with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M500.						
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse		M0500				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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M0500	Continued from page 1 medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;	M0500					

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M0500	Continued from page 2 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interviews, and facility	M0500					

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M0500	Continued from page 3 policy review the facility failed to immediately notify the residents' physician and Resident Representative (RR) following a change in condition involving one (1) of three (3) residents reviewed for notification requirements. Resident #1 Findings Include: Record review of the facility policy, "Accident/Incident Reports", reviewed 9/25 revealed "1. All accidents/incidents including residents, employees, or visitors, will be reported to the Charge Nurse and to the appropriate department head immediately upon knowledge of occurrence, so that it may be evaluated. Accident/Incident is defined as an unexpected happening which may or may not have caused loss or injury to a visitor, resident, and/or staff person (i.e., a resident fall; a staff person closing finger in door; resident hitting staff member; a resident choking in the dining room; or resident wandering out of the community..." An interview on 5/28/26 at 12:16 PM, with Licensed Practical Nurse (LPN) #1 revealed that on the night of 3/15/26, she found Resident #1 with abrasions to both knees after Certified Nursing Assistant (CNA) #1 reported to her that she had found the resident on the floor earlier in the evening around 11:00 PM. She noted that she cleaned the resident's knees and notified the Nurse Practitioner (NP) of her findings who in turn ordered an x-ray. She stated she asked CNA #1 three times did the resident fall out of the bed. Each time CNA #1 denied it and stated instead that she had found the resident lying in an awkward position in the bed. She noted that on 3/19/26 after an interview with CNA #1, the Director of Nurses (DON) and the Administrator that CNA #1 revealed that the resident was found on her knees in on the floor and had returned her to bed without getting another staff member to witness or aid in transfer. An interview with Registered Nurse (RN) #1 at 12:20 PM on 5/28/26, revealed she was not present on the night when the Resident #1 was found to have abrasions to her knees, but was at work on 3/19/26 when the family members of Resident #1 came to the facility expressing concerns related to the resident's injuries. An interview at 1:23 PM on 5/28/26, with the Nurse Practitioner (NP) revealed the resident was seen by	M0500					

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M0500	Continued from page 4 her on 3/17/26. She believed that her injuries were consistent with a fall which was not reported by the CNA. She noted that abrasions were visible on both knees and since then she has assessed the resident who has not exhibited any other issues. An interview with the DON at 2:00 PM on 5/28/26, revealed the facility investigation of the incident indicated the resident fell onto her knees on 3/15/26 and was picked up and put back into bed by CNA #1 who then failed to report a fall to the staff members present that night. CNA#1 eventually admitted on 3/19/26 after being further interviewed that that the resident experienced a fall on 3/15/26. She noted that it is her expectation that CNAs appropriately notify nursing staff of falls so proper care can be administered to residents per policy and that failure to do such can lead to undiagnosed or missed injuries. An interview with at 2:15 PM on 5/28/26 with CNA#1 who was present on the night of the incident stated that the resident was found by herself on the floor on her knees. She noticed her knees were red and had abrasions after she moved her by herself back into the bed. She stated she didn't know that was considered a fall, so she told LPN#1 but didn't tell her the resident fell. She stated LPN#1 took care of the resident's knees and notified the NP of the injuries. She stated after talking to the Administrator a few days later it was made evident to her the incident was a fall and should have been reported as such. An interview on 5/28/26 at 3:05 PM, with the facility Administrator revealed that it is his expectation that staff are expected to promptly report falls so appropriate notifications can be made and residents can receive timely evaluation and care. A record review of Resident #1's "Face Sheet" revealed the facility admitted the resident on 4/4/2023 with diagnoses that included Unspecified Dementia, unspecified severity, with other behavioral disturbance; Major Depressive Disorder; Anxiety Disorder; History of Falling. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/7/2026 revealed Resident #1 was unable to complete a Brief Interview for Mental Status (BIMS).			M0500			