

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 08/27/2026	
NAME OF PROVIDER OR SUPPLIER BRANDON COURT				STREET ADDRESS, CITY, STATE, ZIP CODE 100 BURNHAM ROAD , BRANDON, Mississippi, 39042			
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M0000	Initial Comments		M0000				
M0610	The State Agency (SA) conducted an annual recertification survey at the facility from 08/24/26 through 08/27/26. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M610, M625 and M715. 45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record reviews and facility policy review the facility failed to provide and consistently complete baths, whirlpool baths, nail care and oral care for three (3) of (18) residents reviewed for Activities of Daily Living care. Resident #30, #40 and #53. Findings Include: Record review of the facility's policy, "Activities of Daily Living," revised 09/25, revealed "...ADLs shall include, but are not limited to personal hygiene, bathing, voiding, toileting, repositioning and offering meals..." Resident #30 During an interview on 08/24/2026 at 12:51 PM,		M0610				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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M0610	Continued from page 1 Resident #30 stated he received a whirlpool bath once a week. He stated his last bath was one week earlier. During an interview, on 08/25/2026 at 3:30 PM, during an interview, Resident #30 stated he received a whirlpool bath that day. He stated he would not receive another bath until the following week because he only received one bath each week. During an interview on 08/25/2026 at 3:20 PM, the Director of Nursing (DON) stated Resident #30 should receive a whirlpool bath on each of his scheduled bath days. The DON reviewed Resident #30's bath documentation and confirmed he received only three of the 11 whirlpool baths scheduled during the 30-day review period. The DON confirmed Resident #30's scheduled bath days were Tuesday, Thursday, and Saturday. Record review of Resident #30's "Face Sheet" revealed the facility admitted him on 07/12/2017 with diagnoses that included hemiplegia and hemiparesis following unspecified cerebrovascular disease and morbid obesity due to excess calories. Record review of Resident #30's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/01/2026, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating he was cognitively intact. Section GG revealed Resident #30 required partial or moderate assistance with showering or bathing. Record review of Resident #30's "Personal Hygiene" bath documentation from 7/28/26 through 8/25/26 revealed he received three (3) of the (11) whirlpool baths scheduled for Tuesdays, Thursdays, and Saturdays. Resident #40 During an interview on 08/24/2026 at 11:53 AM, Resident #40 stated she received bed baths weekly. She stated she wanted a complete bed bath instead of perineal care only and had not received a complete bath in several weeks. During an interview on 08/25/2026 at 2:03 PM, Resident #40 stated she received a complete bed bath that day. She stated she was pleased but wanted to receive a complete bed bath on each of her scheduled bath days. During an interview on 08/26/2026 at 3:30 PM, the DON stated Resident #40 should receive a complete	M0610					

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M0610	Continued from page 2 bath on each scheduled bath day. The DON stated failure to provide complete baths could negatively affect the resident's skin, contribute to skin breakdown, and cause emotional distress. The DON stated it was important for residents to receive complete baths on their assigned bath days. Record review of Resident #40's "Face Sheet" revealed the facility admitted her on 03/12/2025 with diagnoses that included unspecified osteoarthritis and urinary tract infection. Record review of Resident #40's MDS, with an ARD of 08/03/2026, revealed a BIMS score of 13, indicating she was cognitively intact. Record review of Resident #40's "Personal Hygiene" bath task documentation from 7/28/26 through 8/25/26 revealed she received five (5) complete baths during the 30-day review period. The remaining documented care consisted of partial baths. During an interview on 08/26/2026 at 1:47 PM, Certified Nursing Assistant (CNA) #1 stated Residents #30, #40, and #53 had scheduled bath days on Tuesday, Thursday, and Saturday. CNA #1 stated she did not know whether Residents #30 and #40 received their scheduled baths. Resident #53 During an observation and interview on 08/24/2026 at 3:42 PM, Resident #53 was seated near the nurses' station. Observation revealed plaque buildup and brownish staining between his teeth. His fingernails were jagged and had a brown substance underneath them. Resident #53 was oriented to person only. During a telephone interview on 08/25/2026 at 10:28 AM, Resident #53's Resident Representative (RR) stated her concerns involved the resident's oral and nail care. She stated she visited him regularly and observed that his teeth were stained and had buildup. She stated Resident #53 had always taken pride in his appearance and personal hygiene. During an observation on 08/25/2026 at 10:57 AM, revealed Resident #53's fingernails remained jagged and dirty. His teeth continued to have yellowish and brown staining with visible plaque buildup between them. During and observation and interview on 08/26/2026 at 1:47 PM, CNA #1 initially stated the Activities	M0610					

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M0610	Continued from page 3 Department provided nail care. CNA #1 then stated CNAs could provide nail care to residents who did not have diabetes. CNA #1 confirmed Resident #53's fingernails were jagged and dirty and required cutting and cleaning. CNA #1 stated she began brushing Resident #53's teeth that morning. Observation revealed his fingernails remained jagged and dirty, and his teeth continued to have visible plaque and staining. During an interview on 08/26/2026 at 3:40 PM, the DON stated the facility did not have a dentist who provided services in the facility. The DON stated the facility was working to arrange dental services. The DON stated residents were referred to an outside dentist for concerns such as tooth pain or broken teeth, but residents were not referred for routine dental cleanings. The DON stated CNAs were responsible for providing oral care three times a day and nurses were responsible for ensuring the care was completed. The DON stated she was also responsible for following up. The DON stated oral care should be provided after each meal and as needed. She stated nail care should be provided once a week and could be performed by a CNA or nurse. The DON stated Resident #53 sometimes refused care and staff should document each refusal. Record review of Resident #53's "Face Sheet" revealed the facility admitted him on 10/22/2021 with diagnoses that included need for assistance with personal care, cerebral infarction due to thrombosis of the left middle cerebral artery, and a history of transient ischemic attack and cerebral infarction. Record review of Resident #53's MDS, with an ARD of 07/08/2026, revealed a BIMS score of 6, indicating severe cognitive impairment. Record review of Resident #53's "Personal Hygiene" task documentation from 7/27/26 through 8/25/26 revealed oral care was documented as completed on 14 days. Nail care was documented as completed on 19 days. The record did not include documented refusals or evidence that staff followed up when the care was not completed.	M0610					
M0625	45.21.5 Range of motion Range of motion. Residents with limited range of motion shall receive treatment and services to increase range of motion or prevent further decline in range of motion. This LICENSURE REQUIREMENT is NOT MET as	M0625					

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M0625	Continued from page 4 evidenced by: Based on interview, record review, and facility policy review the facility failed to assess a resident with a significant bilateral hand contracture and provide appropriate treatment, services, equipment, or positioning interventions to maintain or prevent further decline in range of motion for one (1) of (18) sampled Residents. Resident #62. Findings include: A record review of the facility policy, "Therapy Screenings," revised 10/19, reveals, "Purpose: To identify patients in need of therapy evaluation...Residents are screened according to the following priorities: Newly admitted patients...The Therapy Department should coordinate the therapy screening procedure to ensure completion within 48 hours..." On 8/24/26 at 12:13 p.m., during an interview, Resident #62 stated he had been admitted to the facility approximately 30 days earlier after being diagnosed with Parkinson's disease. He reported that staff had not provided range-of-motion exercises since his admission. During the interview the State Agency (SA) observed Resident #62 had significant contractures of both hands. On 8/26/26 at 1:34 PM, during an interview, the Therapy Director stated it was the facility's standard practice to screen every newly admitted resident within the first week of admission. She explained that members of the therapy staff shared responsibility for completing the screenings and that no specific staff member was assigned to ensure completion. The Therapy Director acknowledged that staff had not completed an initial therapy screening for Resident #62 and could not explain why it had not been completed. She stated the screening would have guided staff in caring for the resident's contracted hands. She explained that the initial screening would have identified possible comfort and positioning measures, including therapy carrots or similar hand-positioning devices. She confirmed that staff had not implemented any interventions or received guidance for managing Resident #62's hand contractures. On 8/26/26 at 2:00 PM, during an interview the Occupational Therapist stated an initial screening	M0625					

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M0625	Continued from page 5 would have included an assessment of Resident #62's functional hand use and the condition of his contracted palms. She stated the assessment would determine whether equipment such as palm protectors was needed to keep the resident's palms dry, protect the skin from nail-related injury, and reduce the risk of maceration. She confirmed that such initial screenings are done when the facility admit new Residents. On 8/26/26 at 2:32 PM, during an interview, the Director of Nursing (DON) stated therapy screenings and recommendations help residents maintain or improve their quality of life. She acknowledged that part of the Therapy Departments role, is to complete an initial screening for every newly admitted resident. On 8/27/26 at 11:27 AM, in an interview with the Administrator, she acknowledged that the therapy team is expected to screen new admits within the first week of admission. She indicated this is done to help keep with the resident current quality of life or see what can be done to improve it as it is their policy to do so. A review of the "Face Sheet" revealed the facility admitted Resident #62 on 7/27/26 with diagnoses that included Parkinson's disease with dyskinesia, without mention of fluctuations, and unspecified nutritional deficiency. A review of the Minimum Data Set assessment (MDS) with an Assessment Reference Date (ARD) of 8/3/26 revealed Resident #62 had a Brief Interview for Mental Status (BIMS) score of (15), indicating intact cognition.		M0625				
M0715	45.24.4 Labeling of drugs Labeling of drugs. Each facility shall follow the Mississippi State Board of Pharmacy labeling requirements. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and facility policy review the facility failed to ensure expired medications were removed from active medication stock for one (1) of two (2) medication carts observed. The 100 Hall medication cart.		M0715				

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M0715	Continued from page 6 Findings Include: Record review of the facility policy "Medication Storage", dated 04/06, latest revision 11/17 revealed, "There shall be storage areas provided... including a separate and secure area shall be provided for the storage of medications that are discontinued, expired, or otherwise unusable..." Record review of the facility policy "Destruction of Unused, Expired or Discontinued Medications", dated 01/13, latest revision 10/19, revealed, "All outdated, discontinued and/or recalled drugs... will be given to the Director of Nursing (DON) for proper disposition. These will be removed during monthly inspections or at any other time as such are found, and will be disposed of..." On 08/25/2026 at 11:30 AM, an inspection of the 100 Hall medication cart was conducted with Licensed Practical Nurse (LPN) #1. The inspection revealed the following: One bottle of Cetirizine HCl 10-milligram tablets remained in active medication stock after the manufacturer's expiration date of 07/2026. During an interview on 08/25/2026 at 11:40 AM, LPN # 1 confirmed the opened, undated medications and the expired medication stored on the 100 Hall medication cart. She stated staff should not use undated medications because they could not determine whether the medications had expired. She stated expired medications could be less effective and could cause a resident to become ill. During an interview on 08/25/2026 at 12:08 PM, the DON was informed of the expired medication identified on the 100 Hall medication cart. She stated expired medications could be less effective, could interact with other medications, and could cause residents to become ill. The DON stated she expected staff to discard expired medications. She acknowledged responsibility for ensuring staff followed these medication-storage practices.			M0715			