STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255106	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brandon Nursing and Rehabilitation Center	355 Crossgate Blvd Brandon, MS 39042

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 37415 Based on observation, interview, record review, and facility policy review, the facility failed to implement a comprehensive care plan intervention related to the removal of a pressure dressing from a dialysis access site for one (1) of four (4) sampled residents. Resident #4. Findings included: A review of the facility's policy, Comprehensive Person-Centered Care Plans, dated 1/2025 revealed, .Each resident will have a person-centered plan of care to identify problems, needs strengths, preferences, and goals that will identify how the interdisciplinary team will provide care .6 Assigned disciplines will be identified to carry out the intervention . A record review of the Care Plan Report for Resident #4 revealed Focus (Proper Name) is at risk for complications .receives hemodialysis .Interventions .Remove pressure dressing four hours post dialysis unless specified by dialysis communication sheet . The intervention was dated 10/15/24. The assigned discipline was listed as Licensed Practical Nurse/Registered Nurse (LPN/RN). On 04/01/25 at 11:41 AM, during an observation with the Unit Manager, Resident #4 was observed to have a bandage still in place on his left arm from his dialysis treatment on 03/31/25. The Unit Manager confirmed the dressing had not been removed and should have been taken off the previous night. A record review of the Order Summary Report revealed Resident #4 had a Physician's Order, dated 8/1/2024, to Remove pressure dressing 6 hours to left forearm dialysis shunt site after returning from dialysis . A record review of the Admission Record revealed the facility admitted Resident #4 on 10/04/2017 with diagnoses including Dependence on Renal Dialysis. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/12/25 revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident was cognitively impaired. During an interview on 4/1/25 at 12:10 PM, the Director of Nursing (DON) confirmed the staff failed to remove the bandage. The DON also confirmed the staff failed to follow the care plan. The DON stated she expects the staff to follow the residents' plan of care. (continued on next page)

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

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/1/25 at 12:25 PM, with LPN #2 confirmed the facility failed to follow the comprehensive care plan by not removing the residents' bandage after dialysis. LPN #2 stated the care plan guides the residents plan of care. The staff are expected to follow the care plan. During an interview on 4/1/25 at 1:40 PM, with the Administrator he stated he did not know the residents' bandage was not being removed after dialysis. The Administrator stated he expects the staff to follow the physician's orders and the dialysis instructions. During a post survey phone interview with LPN #3 on 4/2/25 at 1:20 PM, she confirmed she failed to look at the care plan for Resident #4 regarding removing the pressure dressing.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 37415 Based on observation, interview, record review, and facility policy review, the facility failed to ensure timely removal of a pressure dressing from a dialysis access site for one (1) of one (1) resident reviewed for dialysis services. Resident #4. Findings included: A review of the facility's Dialysis Information Update Transfer Policy, dated February 2019, revealed, Policy: A 'Dialysis Information Update Transfer form' is completed each time a resident receives outpatient dialysis. This ensures enhanced communication between the two facilities .Procedure .3. The bottom section of the form is completed by personnel responsible for the resident at the dialysis facility and returned to the nursing home with the resident .5. As applicable, any instructions related to the resident care received from the dialysis unit should be relayed to the appropriate facility staff .and followed up as indicated. A record review of the Order Summary Report revealed Resident #4 had a Physician's Order, dated 8/1/2024 Remove pressure dressing 6 hours to left forearm dialysis shunt site after returning from dialysis . A record review of the Dialysis Information Update Transfer Form revealed the following instructions written on the communication form to the facility: Remove pressure dressing at 1800 (6PM) dated 3/3/25, Remove compression dressings 4-6 hrs (hours) dated 3/7/25 and Remove compression dressings 4-6 hrs post tx (treatment) @ (at) 1900-2000 (7PM -8PM) dated 3/28/25. On 04/01/25 at 10:00 AM, during an interview with the dialysis nurse, she explained the facility fails to remove the residents' pressure dressings within four (4) to six (6) hours after returning from dialysis. She stated that she had educated the facility staff, Director of Nursing (DON), and Administrator about the importance of timely bandage removal to prevent complications such as clotting or stenosis, which could lead to unnecessary surgical procedures. She referred to the access site as the resident's lifeline. On 04/01/25 at 11:41 AM, during an observation with the Unit Manager, Resident #4 was observed to have a bandage still in place on his left arm from his dialysis treatment on 03/31/25. The Unit Manager confirmed the dressing had not been removed and should have been taken off the previous night. On 04/01/25 at 11:55 AM, during an interview, Resident #4 stated that he told the nurse to remove the bandage, but it was not removed. He explained that he could not remove the dressing himself due to being visually impaired. On 04/01/25 at 12:10 PM, during an interview, the Director of Nursing (DON) confirmed that the staff failed to remove the bandage. She stated she had only been at the facility for three (3) weeks and had not been aware this was a recurring issue. She explained she expected staff to follow both physician orders and instructions provided by the dialysis unit. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/01/25 at 1:40 PM, during an interview, the Administrator stated he was not aware that the bandages were not being removed after dialysis. He reported that he expected staff to follow all physician orders and dialysis instructions. A record review of the Admission Record revealed the facility admitted Resident #4 on 10/04/2017 with diagnoses including Dependence on Renal Dialysis. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/12/25 revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident was cognitively impaired.