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	04/22/2025

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 - Actual harm 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. 47873 Based on observation, interview, record review, and facility policy review, the facility failed to implement the resident's care plan interventions related to daily skin and foot assessments for one (1) of four (4) residents reviewed for care planning, Resident #1, which resulted in the facility not identifying or addressing developing wounds on the resident's foot, which remained untreated by facility staff for five (5) days after being discovered and treated at the dialysis center. Findings include: Record review of facility Comprehensive Person-Centered Care Plan policy dated 01/2025 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 .Procedure .6. Staff approaches are to be developed for each problem/strength/need .Assigned disciplines will be identified to carry out the intervention . A record review of the Care Plan Report for Resident #1 revealed a Focus of (Proper Name) has a dx (diagnosis) of Diabetes Mellitus with interventions including Check all of body for breaks in skin and treat promptly . and Inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness, both initiated on 10/15/24. A record review of the Clinical Notes Report from the dialysis center revealed on 4/16/25 at 11:25 (AM) RN #2 documented that Noted today that (Proper Name of Resident) sock on rt (right) foot had some drainage and the sock was stuck to his great toe and the second toe. Skin was missing in two areas. Color of toes are black in areas. Dead skin filled his sock. Foot very dry. Pressure areas cleaned and betadine applied with a non adhesive bandaid. (Proper Name of Nursing Facility) called and the nurse assigned to (Proper Name of Resident) was given this report and that he will need to be seen in their wound care department. She report she would get the wound care doctor to evaluate. A record review of the facility's Weekly Skin assessments revealed there was no documentation of any wounds to the right foot on 4/16/25 at 2:34 PM, which was after Resident #1 had returned from dialysis in which he received treatments to the right foot wounds. The assessment was completed by LPN #2. (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 - Actual harm Residents Affected - Few	During an observation at the dialysis facility on 04/21/25 at 11:15 AM, Resident #1 had dry scaly feet, thickened dark toenails, and a bandage across the toes dated 04/18/25. Further observation revealed a discolored area on the great toe and missing skin on the second toe. The dialysis nurse confirmed that the bandage was the same one placed on 04/18/25 by her staff. The dialysis nurse stated that although the socks had been changed, the dressing had not been replaced. During an interview on 04/22/25 at 09:30 AM, Licensed Practical Nurse (LPN) #2, who serves as the wound care nurse for Resident #1, it was revealed that the resident's care plan directed daily foot checks for open areas, sores, blisters, etc. LPN #2 stated she was not aware of any calls from an outside agency advising of issues regarding the resident's foot. She confirmed that she completed the body audits 04/16/25 after the resident had returned from dialysis and acknowledged that there was no mention of the wounds documented. After reviewing the dialysis center's documentation dated 4/16/25 regarding Resident #1's wounds, she stated she could neither confirm nor deny that she actually completed the skin check. During an interview on 04/22/25 at 9:56 AM, the facility's Wound Care Physician and LPN #3, they stated they were contracted specialists responsible for providing wound care services to the facility. The Wound Care Physician reported he received a new consultation order for Resident #1 on 04/21/25 at 2:52 PM and stated he had not previously assessed or treated Resident #1 prior to that date. He explained that he first evaluated Resident #1 between 6:00 AM and 7:00 AM on 04/22/25. During an interview on 04/22/25 at 10:00 AM, the facility's Director of Nursing (DON), she acknowledged that staff failed to implement interventions related to Resident #1's care plan regarding skin assessments and foot checks. The DON stated that although the dialysis staff notified the facility of concerns regarding potential skin breakdown and wounds, facility staff did not implement necessary interventions. The DON stated that if the audits had been completed properly, the dressing applied by the dialysis center should have been identified, prompting immediate documentation, further assessment, and medical intervention. During an interview on 04/22/25 at 3:00 PM, facility's Licensed Nursing Home Administrator (LNHA), he stated it was his expectation that staff implement a resident's care plan and promptly report any changes in a resident's condition to the resident's physician, the Director of Nursing (DON), and to himself. A record review of the Admission Record revealed the facility admitted Resident #1 on 10/4/2017 with current diagnoses including End Stage Renal Disease. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/12/2025, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated he had severe cognitive impairment.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 47873 Based on observation, interview, record review, and facility policy review, the facility failed to provide necessary care and services and respond appropriately to changes in a resident's condition for one (1) of four (4) sampled residents (Resident #1), when wounds were identified and treated by the dialysis clinic on 4/16/25 and the facility was notified, but failed to assess or initiate treatment until 4/21/25, resulting in a delay in care and placing the resident at risk for a worsening wound condition and infection. Findings include: A review of the facility's policy, Weekly Skin Audit, dated 11/17, revealed, .A skin audit will be documented on residents weekly. Any identified skin conditions will be documented and treatment initiated .Procedure: 1. Every resident will have a head-to-toe skin evaluation performed and documented on a weekly basis. The evaluation will be documented electronically or on the weekly skin audit form . A review of the facility's policy, Preventative Skin Care, dated 01/15, revealed: It is the practice of this facility to provide routine preventive skin care. This policy will serve as a guide to facilitate staff with regard to clinically acceptable techniques to be applied for skin care prevention .Procedure .4. Provide preventative skin care to all residents. The following interventions should be considered for incorporation into residents' care plans (this is not an all-inclusive list): a. Keep skin clean, dry, and cleansed at the time of soiling and at routine intervals .d. Moisturize skin with lotion to keep skin soft and pliable, giving special attention to participate in prevention . On 04/21/25 at 10:35 AM, during an interview with Registered Nurse (RN) #2 and RN #1 at the dialysis center, RN #2 explained that she was contacted by a staff nurse who had performed a routine foot check on Resident #1. She stated that the resident's sock on the right foot was visibly soiled with drainage and adhered to his great toe and second toe. Upon removal, skin was noted to be missing in two areas, the toes showed black discoloration, and the upper foot was covered with a significant amount of dry, dead skin. RN #2 stated that the pressure areas were cleaned, Betadine was applied, and a non-adhesive bandage was placed over the wounds. She reported that the nursing facility was notified, and the nurse assigned to Resident #1 was informed that the resident required follow-up from the facility's wound care team. RN #2 stated that the nurse at the facility indicated she would contact the wound care physician to evaluate the resident. RN #1 confirmed that she also received a report that wounds with necrotic tissue had been identified during the foot check and interviewed Resident #1, who reported that staff at the facility changed his socks approximately every two weeks, bathed him once per week, and changed his incontinent briefs two to three times daily. RN #1 stated that the concern was reported to the State Agency (SA) and that she and the charge nurse (CN) maintained communication with the facility. She added that after dressing the wounds, the CN placed marked gauze inside the resident's sock in order to assess whether the bandages and socks would be changed prior to the resident's next dialysis visit. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 04/21/25 at 11:00 AM, during an interview, Resident #1 stated that he typically receives bed baths once a week and that his incontinent brief is changed two to three times a day. He acknowledged that on 04/16/25, the nursing staff at the dialysis unit removed his sock and the sock had to be soaked so it could be removed. Resident #1 further acknowledged that the dialysis staff informed him of a possible wound and advised him to follow up with the wound care nurse at his facility. He reported that no one from the facility had checked the dressing on his foot, nor had a doctor evaluated it. He stated that the only dressing changes performed were by the dialysis facility. On 04/21/25 at 11:15 AM, during an observation at the dialysis facility, Resident #1 had dry scaly feet, thickened dark toenails, and a bandage across the toes dated 04/18/25. Further observation revealed a discolored area on the great toe and missing skin on the second toe. The dialysis nurse confirmed that the bandage was the same one placed on 04/18/25 by her staff. The dialysis nurse stated that although the socks had been changed, the dressing had not been replaced. On 04/21/25 at 12:23 PM, during an interview with the facility's Unit Manager, Licensed Practical Nurse (LPN) #1, she stated she had not been informed of any foot issues concerning Resident #1. A review of the 24-hour nursing reports dated 04/16/25 through 04/18/25 revealed no documentation of any communication from the dialysis center regarding foot concerns. Further review of the electronic medical record showed no evidence that a provider had been notified about the resident's foot condition, nor was there documentation of any nursing interventions implemented to address or safeguard the resident's foot health. LPN #1 stated that concerns of this nature should have been documented in the 24-hour report, communicated to the physician in real time, and appropriate medical orders obtained. On 04/22/25 at 09:30 AM, during an interview with the Licensed Practical Nurse (LPN) #2, who serves as the wound care nurse for Resident #1, it was revealed that the resident's care plan directed daily foot checks for open areas, sores, blisters, etc. LPN #2 stated she was not aware of any calls from an outside agency advising of issues regarding the resident's foot. She confirmed that she completed the body audits 04/16/25 after the resident had returned from dialysis and acknowledged that there was no mention of the wounds documented. After reviewing the dialysis center's documentation dated 4/16/25 regarding Resident #1's wounds, she stated she could neither confirm nor deny that she actually completed the skin check. On 04/22/25 at 9:56 AM, during an interview with the facility's Wound Care Physician and LPN #3, they stated they were contracted specialists responsible for providing wound care services to the facility. The Wound Care Physician reported he received a new consultation order for Resident #1 on 04/21/25 at 2:52 PM and stated he had not previously assessed or treated Resident #1 prior to that date. He explained that he first evaluated Resident #1 between 6:00 AM and 7:00 AM on 04/22/25. During the assessment, he described a macule on the resident's great toe as a dry, discolored, palpable area that was not open and had no depth. He stated he also assessed the resident's second toe, which exhibited hyperpigmentation, potentially an early sign of ischemia (lack of blood flow), and described it as dry with darkened skin. The physician emphasized the importance of weekly body audits and stated that he had received consultation requests for other residents based on findings from nursing staff during these audits. He also noted that he had telehealth capabilities available to evaluate urgent concerns remotely and that he visited the facility in person at least once per week. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 04/22/25 at 10:00 AM, during an interview with the facility's Director of Nursing (DON), she acknowledged that staff failed to ensure appropriate wound care, monitoring, and follow-up actions were taken for Resident #1. The DON stated that although the dialysis staff notified the facility of concerns regarding potential skin breakdown and wounds, facility staff did not implement necessary interventions, notify the physician, or initiate appropriate care. She further explained that weekly body audits are conducted for all residents and are expected to include a thorough head-to-toe assessment. The DON stated that if the audits had been completed properly, the dressing applied by the dialysis center should have been identified, prompting immediate documentation, further assessment, and medical intervention. On 04/22/25 at 3:00 PM, during an interview with the facility's Licensed Nursing Home Administrator (LNHA), he stated it was his expectation that nursing staff promptly report any changes in a resident's condition to the resident's physician, the Director of Nursing (DON), and to himself, as appropriate. A record review of the Admission Record revealed the facility admitted Resident #1 on 10/4/2017 with current diagnoses including End Stage Renal Disease. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/12/2025, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated he had severe cognitive impairment. A record review of the Clinical Notes Report from the dialysis center revealed on 4/16/25 at 11:25 (AM) RN #2 documented that Noted today that (Proper Name of Resident) sock on rt (right) foot had some drainage and the sock was stuck to his great toe and the second toe. Skin was missing in two areas. Color of toes are black in areas. Dead skin filled his sock. Foot very dry. Pressure areas cleaned and betadine applied with a non adhesive bandaid. (Proper Name of Nursing Facility) called and the nurse assigned to (Proper Name of Resident) was given this report and that he will need to be seen in their wound care department. She report she would get the wound care doctor to evaluate. On 4/16/25 at 11:48 (AM), RN #3 documented, .In between RT (right) toe and Second toe area is back. Skin breakdown noted to Rt Great Toe and Second toe. Pt sock was stuck to toes .On 4/16/25 at 13:22 (1:32 PM), RN #1 documented, .Rn and CN (Charge Nurse) have communicated with facility, facility states they will get wound care for patient, CN put marked gauze in patient's sock after dressing wounds to see if dressing and/or sock are changed at next visit . A record review of the Clinical Notes Report from the dialysis center revealed on 4/18/25 at 13:22 (1:32 PM), RN #2 documented, Noted today when this RN did a recheck on patient's right foot wound: same sock on foot, same gauge and bandage we applied on foot Wednesday 4/16/25 was discovered . On 4/18/25 at 13:38 (1:38 PM), RN #1 documented, CN checked patient's foot to see if marked gauze was still in sock or wound dressing was changed. The marked gauze was still in patient's sock and dressing had not been changed. CN changed dressing again and placed new marked gauze, will recheck Monday. A record review of the facility's Weekly Skin assessments revealed there was no documentation of any wounds to the right foot on 4/16/25 at 2:34 PM, which was after Resident #1 had returned from dialysis in which he received treatments to the right foot wounds. The assessment was completed by LPN #2. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A record review of the Surgical Note, dated 4/22/25, for Resident #1 revealed a Wound Location of Right great toe that measured 0.4 centimeters (cm) x 0.4 cm x 0.0 cm wound, area 16 cm^2. Another Wound Location of right second toe that measured 5.0 cm x 2.0 cm x 0.0 cm wound, area 10 cm^2.