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	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brandon Court	100 Burnham Road 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and facility policy review the facility failed to immediately notify the resident's 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 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 [DATE] 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 so 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 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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).