STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brandon Community Care 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and facility policy review the facility failed to ensure the resident environment remained as free as possible from accident hazards and that each resident received adequate supervision and assistance to prevent accidents for one (1) of four (4) sampled residents reviewed for falls. Resident # 1. Findings include:Record review of the facility policy Safety and Supervision of Residents, undated, revealed, Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.Record review of the facility policy Homelike Environment undated, revealed, Policy Statement: Residents are provided a safe.homelike environment.Record review of the Facility Self-Reported Incident for Resident #1 dated 12/26/25, revealed that Resident #1 had a fall in her room. Staff heard the resident crying and entered the room and found the resident lying face down on the floor in a pool of blood. The resident was assessed and noted to have discoloration to the left and right eye, noted bruising to her left knee. The resident was sent out to the emergency department where she received six sutures to the laceration of the forehead. The resident also received a computed tomography (CT) of the head that identified an acute orbital blowout fracture of the left orbital floor. There was no surgical intervention recommended. During a reenactment the facility determined the housekeeper went in to clean Resident #1's room and thought the resident was bedridden and was also asleep. The housekeeper did not place wet floor signs in place. Record review of a Witness Statement from Housekeeper # 1 dated December 23, 2024, at 11:47 AM, revealed the housekeeper entered the room at approximately 10:30 AM while the resident was asleep. The housekeeper cleaned and mopped the floor, left the door open to dry, and did not place a wet floor sign because none were available and the housekeeper believed the resident was bedridden. The housekeeper stated it was their first time working on the unit.Record review of the Progress Notes *NEW* dated 12/23/25 at 11:54 AM revealed staff heard Resident #1 crying and upon entering the room observed that the floor was wet and the resident was lying face down on the floor with hair and face covered in blood. Upon assessment it was discovered the resident had a 2 centimeter (cm) laceration to the top of the head, a .75 cm laceration to the forehead, a .25 cm laceration on the bridge of the nose, black and bluish discoloration to the left eye, discoloration to the right lower eyelid, and bluish/black discoloration to the left knee. Emergency officials were notified and Resident# 1 was sent out to the emergency department due to multiple head injuries. Record review of the Progress Note-History dated 12/23/25 and signed by the Family Nurse Practitioner (FNP) revealed Resident #1 was seen on the floor with blood pooled around her head. She had a laceration on her left forehead one to her nose. She has a contusion over the left eye forming.Record review of the local hospital History and Physical dated 12/23/25 and signed by a physician revealed Resident #1 experienced a fall at skilled nursing facility and sustained facial trauma, orbital fracture and suspected concussion and was (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	admitted to the acute care hospital. The laceration required sutures. A computed tomography (CT) of the head and cervical spine indicated no fractures but Resident #1 did not require urgent maxillofacial surgical evaluation, but conservative management. Resident #1 admitted to some pain involving left eye and orbit. On 1/12/26 at 10:15 AM, during an interview the Director of Nursing stated Resident #1 experienced a fall on 1/23/25. The resident was last seen at approximately 10:55 AM and was found around 11:00 AM lying face down on the floor. She confirmed the floor was wet due to recent mopping by housekeeping and no wet floor sign had been placed. She stated the housekeeper assumed the resident was asleep and not mobile. She confirmed the resident sustained multiple lacerations and an orbital fracture and was transported to the emergency room. She stated the housekeeper was disciplined and housekeeping staff were reeducated on wet floor signage.On 1/12/26 at 11:06 AM, during an interview with the Environmental Services supervisor, she stated she was notified of the fall and informed the Administrator and Director of Nursing. She later observed the same housekeeper had mopped two additional rooms with soaked floors and no wet floor signs in place. She reminded the housekeeper that wet floor signs are available on every unit and must be placed before mopping and remain until floors are dry.In an interview conducted on 01/12/2026 at 11:07 AM, Certified Nursing Assistant (CNA) # 1 stated she last saw the resident after assisting her with a shower and returning her to her room. CNA # 1 stated that Resident #1 had been sitting up watching television. She later heard someone calling out for help, walked toward the sound, and entered the resident's room to find her lying face down on the floor, crying. CNA # 1 reported that the floor was wet and no sign was in place, and that housekeeping was contacted to assess it. She remained with the resident until the emergency medical services (EMS) arrived. On 1/12/26 at 11:15 AM, during an interview with Licensed Practical Nurse (LPN) #1, she stated she was alerted by the crying resident. Upon entering the room, she stumbled and questioned why the floor was wet. She observed the resident lying face down on the floor with blood on her face and hair. Resident #1 was assessed, injuries were identified, the Resident Representative was notified, and EMS were contacted.On 01/12/26, at 1:06 PM, during an interview, the Licensed Nursing Home Administrator (LNHA) stated that on 12/23/25, Resident # 1 was discovered lying face down on the floor in her room by nursing staff after they were alerted by the resident's audible cries. The fall was determined to have occurred shortly after 10:55 AM, as that was the last time the resident had been seen by staff. At the time of discovery, the floor was wet from a recent mopping, and no wet floor signage had been placed. The LNHA confirmed that the housekeeper had entered the room around 10:30 AM and mopped the floor without posting a wet floor caution sign. The housekeeper later reported assuming the resident was in bed asleep and did not expect her to get up unassisted. The LNHA acknowledged this assumption was inappropriate and a direct violation of training and facility policy. The LNHA stated that the housekeeper was terminated due to noncompliance with facility policy and failure to adhere to prior training regarding environmental safety, specifically the use of wet floor signage and awareness of resident mobility risks. The LNHA further confirmed that staff failed to identify the wet floor as a potential hazard prior to the incident.Record review of the admission Record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease and unsteadiness on feet.Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/23/25 revealed staff assessed the resident for mental status and documented the resident had memory problems and had some difficulty in new situations only.