STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255160	A. Building B. Wing	11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Daniel Health Care Inc Dba the Meadows	1905 South Adams Street Fulton, MS 38843

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. (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	Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure the safety of a resident during a mechanical lift transfer and a resident sustained a forehead laceration requiring sutures for one (1) of four (4) residents sampled. Resident #1Findings include:Record review of facility policy titled, Total Lift Policy with revision date of 2/2/17 revealed, It is the policy of the facility that a total lift will be utilized as follows: by a licensed nurse or CNA (Certified Nursing Assistant) . It requires two employees when lift is used .A phone interview with CNA #1 on 11/3/25 at 10:40 AM, revealed she was the CNA caring for Resident #1 when the lift incident occurred. She admitted that she transferred the resident without assistance and did not position the lift legs properly which caused the lift to tilt and the bar hit the resident on the forehead. She revealed I tried to do it by myself, and it didn't go well. She acknowledged that some of the staff were in an in-service, but there were others available to assist, but she did not ask for help to move the resident. She acknowledged she had been in-serviced multiple times on lift safety and the requirement for two staff members to be present when a lift was used and she failed to follow this policy. She stated she had not done this before, and she knew she made a big mistake and a bad judgement call and was remorseful that because of her bad decision a resident was harmed and required stitches to her head. An observation on 11/3/25 at 11:30 AM revealed Resident #1 sitting in her geriatric chair in the day room. The laceration on her forehead was healed with an L-shaped scar visible that was approximately two inches long on vertical part and approximately one and one-half inch long on the horizonal part. During an interview on 11/3/25 at 3:10 PM, Registered Nurse (RN) #1 revealed she was the nurse supervisor when the incident occurred. CNA #1 came to her office and told her the resident's head was bleeding. When she arrived in the room, Resident #1 was in the geriatric chair still attached to the lift and her forehead was bleeding, so she held pressure to the wound. There were no other staff member in the room, so she asked CNA #1 if she used the lift by herself and she admitted she did. She stated she told CNA #1, You know better than that. We always use two people. She revealed she notified the Nurse Practitioner (NP) who evaluated the resident and gave orders to send the resident to the emergency room (ER). On 11/3/25 at 4:00 PM, an interview with the Director of Nursing (DON) revealed CNA #1 had been in-serviced multiple times on lift safety which included the requirement to always use two (2) people and CNA #1 did not follow that procedure. Due to this, Resident #1 had a forehead laceration injury that required sutures. She acknowledged that it was her expectation for all staff to follow the policies of the facility to ensure residents' safety. She confirmed the facility failed to ensure the resident was free from injury by a staff member not following facility's policy related to lift use.During an interview on 11/3/25 at 4:05 PM, the Administrator revealed that it was her expectation that each staff member follow policies to safely meet the needs of each resident and CNA #1 failed to do that when she chose to use a lift for Resident #1 without assistance. This led to a forehead laceration that required sutures. She confirmed the facility failed to prevent an accidental injury to a resident by not properly using a lift for a resident's transfer.Record review of Interdisciplinary Progress Notes dated 10/9/25 at 10:09 AM, revealed. This nurse was approached by CNA needing assistance in patient room due to head bleeding. When this nurse entered room resident noted sitting in Geri chair with Hoyer lift still attached to sling. A large laceration was noted to resident's right forehead. This nurse applied pressure to stop the bleeding and called for (proper name removed), DNP (Doctor of Nursing Practice) to come assess, treat. It appears resident head was struck on Hoyer lift during transfer. This note was signed by RN #1Record review of Nurse Practitioner's Interdisciplinary Progress Notes dated 10/9/25 at 10:37 AM revealed, .(proper name for Resident #1 removed) complains of pain to head and I have asked nursing staff to administer Tylenol. Orders given to transfer to (name of local hospital removed) ER for evaluation and management of the laceration. She will need Computed Tomography (CT) to determine any further injury . Record review of Interdisciplinary Progress Notes dated 10/9/25 at 10:50 AM, revealed, .Resident transferred to (proper name of hospital removed) via EMS (Emergency Medical Service) Ambulance Service. Record review of Interdisciplinary Progress Notes dated 10/9/25 at 3:40 PM, revealed, Resident returned from (proper name of hospital removed) via ambulance. On assessment, resident noted to have dressing to forehead. Dressing removed and noted to have 11 stitches to laceration and dressing replaced .Record review of Physician Orders revealed an order dated 8/6/25 for Tylenol 325 milligrams tablet two tablets every four hours as needed for pain.Record review of Electronic Medication Record revealed Tylenol was administered on 10/9/25 at 10:38 AM with reason of grimacing d/t (due to) laceration on right forehead