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	05/29/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, staff interviews, record review, and facility policy review, the facility failed to promote dignity by not ensuring the use of a privacy cover for the urinary catheter bag for one (1) of five (5) residents reviewed with a catheter. (Resident #2) Findings Include: Review of the facility policy titled Catheter Placement Policy, with a revision date of August 14, 2017, revealed catheter bags should be placed inside a privacy bag. Review of the facility policy titled Dignity Policy, with a revision date of September 6, 2010, revealed care should be provided in a manner and in an environment that maintains or enhances each resident's dignity with respect in full recognition of his or her individuality. On 5/27/25 at 9:40 AM, observation of Resident #2 revealed the resident lying in bed with a urinary catheter bag hanging at the bedside, uncovered and lacking a privacy cover. Record review of the physician orders revealed Resident #2 had an order for a suprapubic catheter. During an interview with Licensed Practical Nurse (LPN)# 1 at Resident 2's bedside on 5/28/25 at 9:42 AM, she confirmed that the resident should have a privacy cover on his catheter bag and stated, It can be embarrassing for the resident, and it's a dignity issue. During an interview with Director of Nursing (DON) on 5/28/25 at 11:47 AM, she stated, All staff know that they should have a privacy bag over the catheter bag for dignity. We have enough catheter bag covers for the wheelchair and bed. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/14/2025, revealed in Section C a Brief Interview for Mental Status (BIMS) score was an 8, indicating the resident's cognitive status was moderately impaired. Item H0100: Appliances revealed, A. Indwelling catheter. Record review of the Record of admission revealed the facility admitted Resident #2 on 8/19/2017, with medical diagnoses including Urinary Retention.

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. Based on resident and staff interviews, record review, and facility policy review, the facility failed to involve a bed-bound resident for a scheduled care plan meeting for one (1) of 21 sampled residents. Resident #80 Findings Include: Review of the Care Plan Invitation Policy unrevised revealed, It is the policy of this facility that invitations to care plan conferences will be handled in the following manner: The resident and/or the responsible party will be invited to attend the care planning conference by one week prior to the scheduled date . A formal interdisciplinary care planning conference will be held weekly on Thursday. All members present are to provide input and sign the care plan verifying attendance . Review of the Resident Rights Policy with a revision date of 12/06/10 revealed under, Exercise Rights: Each resident will be able to exercise his/her rights as a resident in this facility and as a citizen of the United States. 11. To participate in his/her total care plan preparation and implementation . An observation and interview with Resident #80 on 5/27/25 at 10:06 AM revealed she was lying in bed and stated she was bed bound and did not attend her care plan meetings because she did not leave her room. The resident explained she had never been invited to a meeting, and the facility had not mentioned anything about having one and confirmed that her family was not involved with her care. An interview with Social Services (SS) #1 on 5/27/25 at 2:12 PM revealed the facility has care plan meetings every Thursday. She explained that she notifies the residents of their upcoming care plan meeting when she goes into their rooms to do their Brief Interview for Mental Status (BIMS) and mood assessment. She stated the resident's son-in-law came to the first couple of care plan meetings but has not come in quite a while. SS #1 stated the resident prefers not to come out of her room and confirmed the team did not accommodate for the resident by holding the meeting in her room. She acknowledged the resident should be involved and make decisions regarding her care. An interview with the Director of Nursing (DON) on 5/29/25 at 8:12 AM confirmed the staff should involve Resident #80 in care plan meetings and explained the resident should have a direct voice regarding how her care was managed. Record review of the Record of Admission revealed the facility admitted Resident #80 on 10/31/23 with medical diagnoses that included Seizures and Unspecified Sequelae of Nontraumatic Subarachnoid Hemorrhage. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/24/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #80 was cognitively intact.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to allow a resident the opportunity to make important care-related decisions for one (1) of 21 sampled residents. Resident #87 Findings Include: Review of the Resident Rights Policy with a revision date of 9/06/10 revealed under, Exercise Rights: Each resident will be able to exercise his/her rights as a resident in this facility and as a citizen of the United States. An observation and interview with Resident #87 on 5/27/25 at 10:56 AM revealed she was sitting in her wheelchair in her room and stated that she did not sleep well last night and explained that they made her get up early this morning. She revealed, I told them I would rather not get up, and I wanted to sleep in. The resident stated that they made her get up anyway. An interview with Resident #87 on 5/28/25 at 9:50 AM revealed she was [AGE] years old, and depending on how she felt, she might not want to get up early every morning. The resident stated she would like to make those care decisions for herself. An interview with Licensed Practical Nurse (LPN) #2 on 5/28/25 at 10:02 AM revealed Resident #87 was on the get-up list for the 11-7 shift to get her up. She explained that the night shift started getting the residents up around 5:30 AM and confirmed the resident did voice at times she did not want to get up early, but the daughter wanted her up for all meals. LPN #2 acknowledged it was the residents' right to make care choices, and the facility should honor that request. An interview with the Director of Nursing on 5/29/25 at 8:12 AM confirmed Resident #87 should be able to make decisions regarding her care that were important to her, such as sleeping in late if she wanted to. Record review of the Record of Admission revealed the facility admitted Resident #87 on 5/03/24 with a medical diagnosis that included Mixed Anxiety Disorder. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/04/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 10, which indicated Resident #87 was moderately cognitively impaired.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on staff interviews, record review, and facility policy review, the facility failed to accurately complete Section K of the Minimum Data Set (MDS) for a resident with significant weight loss for one (1) of 21 sampled residents. Resident #48 Findings Include: Review of the facility policy titled Resident Assessment Instrument Policy (RAI) with a revision date of 5/19/15 revealed, It is the policy of this facility that the RAI will be done as follows: According to the guideline specified by CMS (Centers for Medicare and Medicaid Services) . Record review of the Weights Detail Report for Resident #48 revealed the following recorded weights: 3/27/25 237.1 4/29/25 230.3 Record review of the readmission Assessment for Resident #48 dated 5/07/25 revealed a weight of 206.6, which was a significant weight loss of 10.29% (percent) from the last documented weight on 4/29/25. Record review of the Admit 5-day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/13/25 revealed under section K0300, a weight loss of 5% or more in the last month was not marked. An interview with the Minimum Data Set (MDS) Nurse on 5/29/25 at 8:56 AM confirmed Resident #48 had weight loss that should have been captured on the 5-day MDS assessment. She stated, It just got missed. She revealed the information submitted in the assessment must be accurate to develop the resident's care that is needed. An interview with the Director of Nursing (DON) on 5/29/25 at 9:09 AM revealed her expectations were for the MDS staff to accurately reflect the resident's status at the time the assessment was completed. Record review of the Record of Admission revealed the facility admitted Resident #48 on 8/12/24 with a medical diagnoses that included Chronic Kidney Disease, stage 3, and Chronic Systolic Congestive Heart Failure. Record review of the MDS with an Assessment Reference Date (ARD) of 5/23/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 3, which indicated Resident #48 was severely cognitively impaired.