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	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and facility policy review, the facility failed to prevent the possible contamination of ice, as evidenced by a buildup of a black substance on the inside door and the interior ledge of the ice machine that was used for all residents for one (1) of three (3) kitchen tours.Findings Include: Record review of the facility policy titled Ice Machine Cleaning Policy with an effective date of 5/3/2021 revealed, .The kitchen staff will be responsible for weekly cleanings of ice machines in the kitchen .During the initial kitchen tour on 6/1/2026 at 10:24 AM, observation of the ice machine revealed two areas of black substance, each approximately two to three inches in diameter, on the underside of the ice maker lid. Black substance was also observed along the interior ledge of the ice machine. The interior ledge was covered with small, circular spots of the black substance that extended across the entire ledge surface.During an interview on 6/1/2026 at 10:25 AM, the Dietary Manager (DM) confirmed the presence of the black substance observed on the underside of the ice maker lid and on the interior ledge of the ice machine. The DM stated that dietary staff clean the ice machine weekly and that the underside of the lid and the interior ledge should have been cleaned during the routine cleaning process. The DM acknowledged that the black substance should not have been present and that its presence showed the ice machine had not been cleaned properly. The DM also stated that the black substance could potentially cause illness in residents and staff.

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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on record review, staff interview, and facility policy review, the facility failed to ensure the designated Infection Preventionist implemented and monitored the facility's Infection Prevention and Control Program by failing to conduct infection surveillance, track and trend infections, analyze infection data and identify infection control concerns. This deficient practice had the potential to affect all 118 residents residing in the facility.Findings Include:Record review of the facility policy titled Compliant Infection Preventionist (IP) Job Description revealed under, Position Summary: The Infection Preventionist (IP) is responsible for the development, implementation, oversight, and evaluation of the facility's Infection Prevention and Control Program (IPCP). The IP works collaboratively with nursing, medical staff, department managers, residents, families, and community agencies to prevent, identify, investigate, monitor, and control infections and communicable diseases throughout the facility .Record review of the facility's Urinary Tracking Infection Logs from February 2026 through April 2026 identified 54 urinary tract infection (UTI) episodes, excluding residents admitted with infections and duplicate entries for the same active infection. Multiple residents experienced recurrent UTIs. The infection tracking logs included resident names, organisms identified, antibiotic treatment, treatment completion dates, and follow-up culture results. However, there was no documentation demonstrating the infections were analyzed for trends, contributing factors, recurring organisms, or opportunities for intervention.Record review revealed the May 2026 infection control log had not been completed as of 6/2/26.Record review of Resident #118's physician orders revealed an order dated 6/2/26 for Contact Precautions for ESBL (Extended-Spectrum Beta-Lactamase) in urine every shift.On 6/3/26 at 2:30 PM, during an interview with the Infection Preventionist (IP), she stated she had not completed the May 2026 infection control log and usually remained approximately one month behind in infection control documentation. The IP stated she was unaware a resident was currently on contact precautions for an infection and could not identify the type of infection. She stated floor nurses were responsible for implementing precautions and ensuring the required equipment was available in the resident's room.On 6/3/26 at 10:00 AM, during an interview with the IP, she stated she had served in the role since 2018 and dedicated approximately three days per week to infection prevention activities. The IP stated she was unsure what infection criteria were used to identify infections and would need to review the facility policy. The IP stated she did not review resident symptoms when monitoring infections. The IP stated she only reviewed physician orders for antibiotics and entered the information into the monthly infection tracking log. The IP confirmed she did not track or trend infections, evaluate recurring infection patterns, or analyze infection data. The IP stated UTIs had been a recurring concern within the facility. The IP further confirmed she had not provided staff education regarding perineal care, catheter care, hydration, or other interventions to address the recurring infections.On 6/3/26 at 10:38 AM, during an interview with the Administrator after reviewing the infection tracking logs, confirmed the infection tracking process was lacking.Record review of the facility's Urinary Tracking Infection Logs from February 2026 through April 2026 identified a recurring pattern of urinary tract infections caused by Escherichia coli (E. coli). Despite the recurring trend, there was no evidence the facility conducted surveillance activities to identify contributing factors, determine the source, or implement corrective interventions.An interview on 6/3/26 at 3:45 PM, with the Assistant Director of Nursing (ADON) revealed the IP should identify infection sources, track infection patterns, and ensure interventions were implemented to address identified concerns. The ADON confirmed there was no tracking or trending of infection data. After reviewing the infection logs, the ADON identified a recurring concern involving E. coli in urine cultures and stated staff education regarding perineal care, catheter care, hydration, and other prevention measures should have been conducted. The ADON stated the recurring infections should have been analyzed to identify the cause and implement corrective actions.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on staff interview, record review, and facility policy review, the facility failed to implement an effective antibiotic stewardship program, failed to ensure urinary tract infections (UTIs) were reviewed using established infection criteria before antibiotic treatment, failed to track and trend infection data, and failed to identify and implement interventions to reduce infections for numerous UTI episodes identified on the facility's infection tracking logs from February 2026 through April 2026.This was for three (3) of four (4) months reviewed.Findings include:Review of the facility policy titled Antibiotic Stewardship Policy revealed, It is the policy of this facility to minimize inappropriate and unnecessary antibiotic use and improve patient outcomes. This facility will follow the antibiotic stewardship program. Review of the facility's Urinary Tracking Infection Logs from February 2026 through April 2026 identified 54 UTI episodes, excluding residents admitted with infections and duplicate entries for the same active infection. Multiple residents experienced recurrent UTIs. The infection tracking logs included resident names, organisms identified, antibiotic treatment, treatment completion dates, and follow-up culture results. However, there was no documentation showing the facility reviewed symptoms or infection criteria to determine whether a UTI was present, analyzed antibiotic utilization, identified infection trends, evaluated recurring organisms, or implemented interventions to reduce infections.Record review revealed the May 2026 infection control log had not been completed as of 6/2/26.Record review of Resident #118's physician orders revealed an order dated 6/2/26 for Contact Precautions for ESBL (Extended-Spectrum Beta-Lactamase) in urine every shift.During an interview on 6/3/26 at 2:30 PM, the Infection Preventionist (IP) stated she had not completed the May 2026 infection control log and usually remained approximately one month behind in her infection control documentation. The IP stated she was unaware a resident was currently on contact precautions for an infection and could not identify the type of infection. She stated floor nurses were responsible for implementing precautions and ensuring the required equipment was available in the resident's room.During an interview on 6/3/26 at 10:00 AM, the IP stated she had served in the role since 2018 and dedicated approximately three days per week to infection prevention activities. The IP stated she was unsure what infection criteria were used to determine whether residents met the requirements for a UTI diagnosis and would need to review the facility policy. The IP stated she did not review resident symptoms when tracking infections. When asked how she determined whether infection criteria were met before antibiotics were prescribed, she stated she only reviewed physician orders for antibiotics and entered the information into the monthly infection tracking log. The IP confirmed she did not track or trend infections, evaluate recurring infection patterns, or analyze antibiotic utilization. The IP stated UTIs had been a recurring concern in the facility. She further confirmed she had not provided staff education regarding perineal care, catheter care, hydration, or other interventions to reduce UTI occurrence.During an interview on 6/3/26 at 10:38 AM, the Administrator stated nurses reported resident symptoms to the Nurse Practitioner, who then determined whether testing and treatment orders would be issued. The Administrator reviewed the infection tracking log and confirmed the tracking process was lacking.Record review of the facility's Urinary Tracking Infection Logs from February 2026 through April 2026 identified a recurring pattern of urinary tract infections cause by Escherichia coli (E.coli). Despite the recurring trend, there was no evidence the facility conducted surveillance activities to analyze contributing factors, identify the source, or implement interventions. During an interview on 6/3/26 at 3:45 PM, the Assistant Director of Nursing (ADON) stated the IP should know the infection criteria used to determine whether antibiotic treatment was appropriate. The ADON stated the IP should evaluate whether residents were being treated for a true infection, identify the source of infections, track infection patterns, and ensure interventions were implemented to address identified concerns. The ADON confirmed there was no tracking or trending of infection data. After reviewing the infection logs, the ADON identified a recurring concern involving E. coli in urine cultures and stated staff education regarding perineal care, (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	catheter care, hydration, and other prevention measures should have been conducted. The ADON stated the recurring infections should have been analyzed to identify the cause and implement corrective actions.

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F 0656 Level of Harm - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, and facility policy review, the facility failed to ensure comprehensive Activities of Daily Living (ADL) care plans were implemented for two (2) of 25 residents sampled. Specifically, the facility failed to implement established ADL care plan interventions related to facial hair for Residents #59 and #67. Findings include: Review of facility policy titled Total Care Plan Policy revised 5/19/2015, revealed, .Identify problems that affect the residents and his/her care needs .Identify the interventions related to the specific problems .Be maintained on the extent practicable . Resident #67 Review of Resident #67's ADL care plan dated 11/6/25, revealed, .Place personal hygiene items within reach and allow to perform per self. Assist to complete tasks as needed. On 6/1/2026 at 11:35 AM, an observation revealed Resident #67 had several long, curly facial hairs on her chin. On 6/3/2026 at 10:00 AM, during an interview Registered Nurse (RN) #2 confirmed the presence of the chin hairs, and she further confirmed that Certified Nursing Assistants (CNAs) should be shaving residents as needed during bath/shower time. During an interview on 6/4/2026 at 8:34 AM, the Minimum Data Set (MDS) Nurse confirmed Resident #67's ADL care plan was developed to include personal hygiene, it was just not implemented by the staff. She verbalized that the purpose of the care plan is to guide the staff on how to provide care for Resident #67. Record review of the Record of admission indicated Resident #67 was admitted to the facility on [DATE]. Record review of the Client Diagnosis Report indicated Resident #67's diagnoses included Unspecified fracture of upper end of right tibia, subsequent encounter for closed fracture with routine healing; weakness; vascular dementia, unspecified severity, with other behavioral disturbance. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/17/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 4, indicating Resident #67 had severe cognitive impairment. Under Section GG revealed that she required supervision or touching assistance with her personal hygiene. Resident #59 Record review of Resident #59's Care Plan revealed that she had limitations in functional abilities/self-care deficit related to generalized weakness with a goal that all Activities of Daily Living (ADL) needs will be met with staff assistance as required. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/01/2026 at 1:35 PM and on 06/03/26 at 9:50 AM, observations and interviews revealed Resident #59 with scattered chin hairs that were approximately one-half to three-fourths of an inch in length. Resident #59 revealed that she could not recall staff asking her if she would like them shaved and stated, It would be good if they had a time and place to get it done. Resident revealed that it bothered her to have facial hair and stated, It makes me feel like an odd ball. On 06/03/26 at 9:55 AM, during an interview and observation with Certified Nursing Assistant (CNA) #1, she confirmed that Resident #59 had facial hair to her chin. CNA #1 revealed that Resident #59's scheduled shower days were Mondays, Wednesdays, and Fridays and confirmed that her facial hair should have been taken care of. An interview on 06/03/26 at 10:05 AM with Assistant Director of Nursing (ADON), revealed that she wanted the residents to look nice, look presentable, and to feel good about themselves. ADON revealed that they expected their CNAs to assess for facial hair on male and female residents during their shower time. She confirmed that Activities of Daily Living (ADL) Care was including on the Care Plan and should have been completed. She also revealed that leaving female residents with unwanted facial hair was a dignity issue and was not acceptable. Record review of Resident #59's Record of admission form revealed an admission date of 01/20/25 and that she had diagnoses that included Unspecified Dementia, Weakness, and Hypertensive Heart and Chronic Kidney Disease without Heart Failure. Record review of Resident #59's Brief Interview for Mental Status (BIMS) Assessment completed on 03/20/26 revealed a score of 08 which indicated that she had moderate cognitive deficits. Record review of Resident #59's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 04/12/26 under Section GG revealed that she required substantial/maximal assistance with her personal hygiene.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, record review and facility policy review the facility failed to provide necessary Activities of Daily Living (ADL) services for two (2) of 25 sampled residents who were dependent on staff assistance to maintain their personal hygiene and grooming needs. Resident #59 and Resident #67. Findings include: Review of facility policy titled Dressing and Grooming Policy revised 11/20/2017, revealed, It is the policy of this facility that dressing, and grooming will be done as follows: Grooming includes: .shaving, removal of facial hair . Resident #67 During an observation on 6/1/2026 at 11:35 AM, revealed Resident #67 had several long, curly facial hairs on her chin. During an observation an interview with Resident #67 on 6/3/2026 at 9:56 AM, revealed Resident #67 still had multiple long, curly chin hairs. She stated, while feeling her chin, I didn't know those were there. She verbalized she would like someone to shave those off. During an interview on 6/3/2026 at 10:00 AM, Registered Nurse (RN) #2 confirmed the presence of the chin hairs, and she further confirmed that Certified Nursing Assistants (CNAs) should be shaving residents as needed during bath/shower time. Additionally, she stated that when female residents have unwanted facial hair, it is considered a dignity concern. During an interview on 6/3/2026 at 10:05 AM, the Assistant Director of Nursing (ADON) confirmed that it was the responsibility and expectation for the CNA to shave residents as needed on shower days or as needed. She stated it was a dignity issue for female residents to have unwanted facial hair. Record review of the Record of admission indicated Resident #67 was admitted to the facility on [DATE]. Record review of the Client Diagnosis Report indicated Resident #67's diagnoses included weakness and vascular dementia, unspecified severity, with other behavioral disturbance. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/17/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 4, indicating Resident #67 had severe cognitive impairment. Section GG revealed that she required supervision or touching assistance with her personal hygiene. Resident #59 Observations and interviews on 06/01/2026 at 1:35 PM and 06/03/26 at 9:50 AM revealed Resident #59 with scattered chin hairs that were approximately one-half to three-fourths of an inch in length. Resident #59 revealed that she could not recall staff asking her if she would like them shaved and (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated, It would be good if they had a time and place to get it done. Resident revealed that it bothered her to have facial hair and stated, It makes me feel like an odd ball. She also revealed that she did not want her facial hair plucked out, but she would like it to be shaved. During an observation and interview on 06/03/26 at 9:55 AM with Certified Nursing Assistant (CNA) #1, she confirmed that Resident #59 had facial hair to her chin. CNA #1 revealed that Resident #59's scheduled shower days were Mondays, Wednesdays, and Fridays and confirmed that removal of facial hair was the CNAs responsibility to take care of during that time. She stated, I don't like to have body hair myself and revealed she would take care of it. During an observation and interview on 06/03/26 at 10:00 AM with Licensed Practical Nurse (LPN) #2, she confirmed that Resident #59 had facial hair to her chin. She stated, I wouldn't like to have facial hair, it would bother me too. She also revealed that facial hair should be addressed during resident showers. An interview on 06/03/26 at 10:05 AM with Assistant Director of Nursing (ADON), revealed that she wanted the residents to look nice, look presentable, and to feel good about themselves. ADON revealed that they expected their CNAs to assess for facial hair on male and female residents during their shower time. She also confirmed that leaving female residents with unwanted facial hair was a dignity issue and was not acceptable. Record review of Resident #59's Record of admission form revealed an admission date of 01/20/25 and that she had diagnoses that included Unspecified Dementia, Weakness, and Hypertensive Heart and Chronic Kidney Disease without Heart Failure. Record review of Resident #59's Brief Interview for Mental Status (BIMS) Assessment completed on 03/20/26 revealed a score of 08 which indicated that she had moderate cognitive deficits. Record review of Resident #59's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 04/12/26 under Section GG revealed that she required substantial/maximal assistance with her personal hygiene.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review and facility policy review, the facility failed to implement and maintain an effective infection prevention and control program by failing to follow Enhanced Barrier Precautions (EBP) (Resident #91) and by failing to provide an appropriate biohazard (red barrel) container for a resident under transmission-based precautions. (Resident #118) for two (2) of 25 sampled residents. Findings Include: Review of the facility policy titled, Infection Control-Contact Isolation/Transmission Based/Enhanced Barrier Policy with a revision date of August 2024 revealed, 2. Contact Isolation.Red/Yellow bagged barrels will be utilized . Record review of physician orders revealed Resident #118 had an order dated 6/2/2026 for contact isolation precautions related to ESBL (Extended-Spectrum Beta-Lactamase) in urine every shift. An observation on 6/01/2026 at 2:53 PM revealed Resident #118 was on transmission-based precautions related to ESBL. A red bag/ biohazard barrel was not present in the resident's room for disposal of contaminated waste and personal protective equipment (PPE). Gowns, gloves, masks were discarded in a regular trash can in the bathroom. During an observation and interview with Registered Nurse (RN) #1 on 6/01/2026 at 3:05 PM, she stated there should have been a barrel in the room. During an interview on 6/02/2026 at 2:30 PM, the Infection Preventionist (IP) stated, According to the policy, there should have been a red barrel in the room. She also stated, I didn't even know that Resident #118 was on contact precautions, I'm not sure what type of infection she has. She stated, It's the first of June and the report is one month behind. During an interview on 6/04/2026 at 8:37 AM with Assistant Director of Nursing (ADON), she confirmed infection control practices should be used to prevent the spread of an infection and stated, It is the expectation of the facility to have biohazard trash bags in the room of a resident on contact isolation. Record review of the Record of admission revealed Resident #118 was admitted to the facility on [DATE] with medical diagnoses that included Cerebral Infarction. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/13/2026 revealed under Section C that a Brief Interview for Mental Status (BIMS) score was 8, indicating moderate cognitive impairment. Resident #91 Review of the facility policy titled Infection Control-Contact Isolation/Transmission Based/Enhanced Barrier Policy, with a revision date of August 2024, revealed .Enhanced Barrier Precautions refer to the use of gown and gloves for use during high contact resident care activities for residents known to be colonized or infected with a MDRO (Multi-Drug Resistant Organism), as well as those at increased (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	risk of MDRO acquisition (e.g. residents with wounds or indwelling medical devices) During an observation and interview on 6/02/2026 at 1:57 PM, signage indicating Enhanced Barrier Precautions was observed posted outside Resident #91's room. Licensed Practical Nurse (LPN) #1 escorted Resident #91 in his wheelchair from the hallway into his room and proceeded to provide Percutaneous Endoscopic Gastrostomy (PEG) tube site care. LPN #1 failed to perform hand hygiene and failed to don the required gown prior to initiating care. During the treatment, LPN #1 cleansed the PEG site and discarded a soiled gauze pad onto the bedside table. LPN #1 immediately stated, Oh, I shouldn't have done that, however, the soiled gauze remained on the bedside table. Upon completion of the treatment, LPN #1 bagged the trash and exited the resident's room to dispose of it while continuing to wear the same soiled gloves. During an interview on 6/02/2026 at 2:10 PM, LPN #1 confirmed Resident #91 was on Enhanced Barrier Precautions and stated, We usually just use gloves when we do his PEG site care. I think we wear gowns and gloves when they have a wound. After reading the Enhanced Barrier Precautions signage posted outside the resident's room, LPN #1 stated, I guess I screwed up. According to the sign, we are supposed to wear a gown since he has a PEG tube. LPN #1 further acknowledged that wearing the same soiled gloves from the resident's room into the hallway was an infection-control concern and that the gloves should have been removed and discarded before exiting the room. During an interview on 6/02/2026 at 2:40 PM, the Infection Preventionist confirmed that Enhanced Barrier Precautions are required when providing PEG site care and explained that these precautions are intended to reduce the risk of transmission of infectious organisms. During an interview on 6/03/2026 at 4:05 PM, the Assistant Director of Nursing (ADON) revealed it is the facility's expectation that infection control practices are consistently followed to prevent the spread of infection. The ADON confirmed staff are trained to wear the appropriate personal protective equipment (PPE), including both a gown and gloves, when providing care to residents on Enhanced Barrier Precautions. The ADON further stated that proper hand hygiene and removal and disposal of soiled gloves before leaving the resident's room are expected infection control practices. Record review of the Record of Admission revealed Resident #91 was admitted to the facility on [DATE] Record review of the Client Diagnosis Report revealed Resident #91 has diagnoses which include Dysphagia following cerebral infarction, and Encounter for attention to gastrostomy. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/3/26 revealed under Section K. that Resident #91 had a Feeding tube.