STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255213	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadville Convalescent Home	300 Hwy 556/Route 2 Box 66 Meadville, MS 39653

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. 42807 Based on record review, staff, and Resident Representative (RR) interviews and facility policy review, the facility failed to notify the resident's RR of change a in the resident's condition for one (1) of four (4) sampled residents. (Resident #1) Findings include: Review of the facility's policy titled, Notification of Significant Changes, dated 10/17/14, revealed, POLICY: The facility shall immediately inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative or an appropriate family member of the following: .Significant change in resident's physical, mental or psychosocial status . On 5/30/24 at 12:20 PM, during a telephone interview with the RR for Resident #1, he reported that he had not been notified that Resident #1 had a change of condition on 12/03/23. He stated that he was not notified until the resident experienced another change of condition on 12/06/23. Record review of the Progress Notes, for Resident #1 revealed that on 12/03/23 at 2:40 AM, the resident had an elevated temperature and productive cough and tested positive for COVID-19. There was no documentation of notification of the resident's RR. Record review of Progress Notes, for Resident #1 revealed that on 12/06/23 at 1:54 PM, there was a change noted in the resident's condition. The nurse noted a finger stick blood sugar revealed a reading as High. The Nurse Practitioner was notified, and new orders received regarding the resident's insulin orders. There was documentation, at that time, that there was an unsuccessful attempt to notify the RR. At 3:24 PM, the resident was unresponsive to verbal or tactile stimulation and the resident was transferred to a local acute care facility. Once again, there was an unsuccessful attempt to notify the RR. The RR returned the call at 4:05 PM and was notified of the resident's change of condition and transfer. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/24 at 2:25 PM, an interview with the Director of Nurses (DON) revealed that nurses were supposed to notify residents' RR of a change of condition, which would include a positive COVID-19 test. She stated that nurses were also supposed to document in Nurses Progress Notes that the RR was notified along with the time, date, and RR's response. She stated that if the nurse were unable to reach the RR by telephone, the attempt should be documented and passed along with instructions for the on-coming nurse to notify the RR. The DON stated she had not notified the RR of the change of condition for Resident #1 on 12/03/23, and was not able to find any documentation that an attempt was made. On 5/30/24 at 2:35 PM, during an interview with Charge Nurse #1, she revealed she had not notified the RR for Resident #1 of the resident's change of condition on 12/03/23, or at any time prior to 12/6/23. On 5/30/24 at 3:00 PM, an interview with Licensed Practical Nurse (LPN) #2, revealed she was not on duty on 12/03/23, but was assigned to the care of Resident #1 on 12/04/23 and 12/05/23. She stated the resident was on infection control precautions for COVID-19, but was alert and oriented with a cough. She stated that she had not notified Resident #1's RR of the change of condition. Record review of the Admission Record for Resident #1, revealed the facility admitted the resident on 12/1/22 and discharged the resident on 12/9/23. The resident had diagnoses that included Unspecified Dementia with Anxiety, Type 2 Diabetes. There was a diagnosis of COVID-19 with an onset date of 12/3/23.