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	11/12/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility policy review and interviews, the facility failed to ensure the resident's right to be informed of, and participate in, treatment decisions, including the right to be fully informed in advance of the care to be furnished, the type of practitioner providing treatment, and the risks and benefits of proposed care for one (1) of ten (10) sampled residents (Resident #3).Findings Included:A policy review of the facility's policy titled Standard of Care, with a revision date of 9/15/25, revealed the policy stated, It is the policy of this facility to provide a standard of treatment and care most beneficial to residents. Regardless of payment methods, all residents shall have access to. Care that meets their needs, Their attending physician, Clinical and administrative staff. In providing care to all residents our staff will be. effective communicators with one another.A policy review of the facility's policy titled Medical, Dental and L.I.P. Providers: Selection, Appointments and Communications, with a revision date of 11/28/17, revealed the policy stated, The facility shall support each resident's right to fully choose a personal physician, dentist, and other licensed independent practitioner. Residents and/or family members may request information regarding the physicians and other practitioners responsible for his/her care. A.H.M. facilities shall provide the health care provider's name, credentials and phone number to the resident/family.A record review of the admission Record for Resident #3 revealed Resident #3 was admitted on [DATE] with an initial admission date of 4/03/24. Diagnoses included osteomyelitis of vertebra, sacral and sacrococcygeal region (onset 4/04/24), peripheral vascular disease, diabetes, dementia, and Stage 3 pressure ulcers of the right heel and other sites. Medical Director (MD) #1 was the documented primary physician, and the resident's power of attorney (POA) was his nephew.A record review of the Quarterly Minimum Data Set (MDS) with Assessment Reference Date 9/25/25 revealed a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. The MDS revealed Resident #3 required supervision for eating, was dependent on all other ADLs, used a wheelchair for mobility, and had unhealed pressure ulcers, including two Stage 3 ulcers and one Stage 4 ulcer.A review of the Wound Log dated 8/06/25 revealed Medical Director #1 documented that wound cultures obtained three months earlier grew Proteus, Staph, and Enterococcus, with sensitivities indicating Zyvox and Vancomycin as drugs of choice. He documented that a repeat culture might be considered the following week and that a Percutaneous Intravenous Central Catheter (PICC) line could be needed if indicated.A record review of a progress note dated 8/11/25 revealed, Verbal consent obtained per resident's RP (Family Member/Not Responsible Party) for MDB to see resident, entered as a late entry by the DON on 8/20/25.A record review of progress notes dated 8/11/25 at 17:28, entered by LPN #1, revealed communication with the Resident Representative (RR) regarding a thyroid nodule and consultation for biopsy. The RR stated, I say leave it alone. MD #2, the Director of Nursing (DON), and the administrator in training were notified. The RR was also informed of the residents' swallowing difficulties.On 11/11/25 at 1:00 PM, an interview with the Administrator revealed the facility decided-without input from affected residents or their representatives-to discontinue sending residents, including Resident #3, to the local wound care clinic where they had been treated by Medical Director #1. Instead, the facility transferred wound care to a certified wound care nurse practitioner providing infacility services. He acknowledged no printed letters were issued, no notifications were made to residents or their RPs, and Resident #3's RR was not contacted, despite documentation that the facility had communicated with the RR regarding other care matters on 8/11/25. He confirmed the change occurred despite opposition from both MD #1 and MD #2 and stated there was no reason residents could not continue receiving wound care both in the clinic and in the facility.On 11/12/25 at 10:57 AM, a telephone interview with Resident #3's RR and POA revealed he had not been notified of the change in Medical Director, the revocation of attending physician privileges, or the transition to an infacility wound care. He confirmed he received no verbal, written, or electronic communication regarding changes in providers or treatment locations and had not been informed of any need to make decisions regarding physician participation. He stated he believed Resident #3 had continued attending weekly wound care clinic visits and was unaware that the resident had missed appointments. He reported that Resident #3 could not make medical decisions and that his placement decision was based on his trust in MD #1 and MD #2.On 11/13/25 at 10:04 AM, during a telephone interview, Medical Director #1 stated he was concerned about Resident #3's sacral and forefoot wounds, which required ongoing monitoring for infection. He stated he had planned to evaluate the resident for potential intravenous antibiotic therapy, including possible PICC line

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F 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to choose his or her attending physician. (continued on next page)

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F 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and facility policy review the facility failed to inform residents/resident representatives that their chosen attending physician was unable to meet requirements as the facility sought to seek alternate physician for provision of care and treatment without attempt to work with the residents' chosen attending physicians or mediate differences for nine (9) of eleven (11) sampled residents; Resident #2, Residents #3, Resident #4, Resident #5, Resident #7, Resident #8, Resident #9, Resident #10 and Resident #11.Findings Included:Policy review of the facility policy titled, Standard of Care with Revision Date 9/15/22 revealed, It is the policy of this facility to provide a standard of treatment and care most beneficial to residents.Regardless of payment methods, all residents shall have access to.Care that meets their needs, Their attending physician, Clinical and administrative staff.In providing care to all residents our staff will be.effective communicators with one another.Policy review of the facility policy titled, MEDICAL, DENTAL AND L.I.P. PROVIDERS: SELECTION, APPOINTMENTS AND COMMUNICATIONS with Revision Date 11/28/2017 revealed POLICY: The facility shall support each residents' right to fully choose a personal physician, dentist and other licensed independent practitioner (L.I.P).PHYSICIAN COMMUNICATIONS: Residents and/or family members may request information regarding the physicians and other practitioners responsible for his/her care. (Proper Name) facilities shall provide the health care provider's name, credentials and phone number to the resident/family.Record review of Residents' Rights with Revision Date 10/10/22 revealed, The resident has the right to a dignified existence, self-determination.3. Choice of attending physician. The resident has a right to choose his or her attending physician. On 11/11/25 at 1:00 PM during an interview the facility Administrator stated that the facility decided, without input from residents who received wound care from the Medical Director (MD) at the local wound care clinic, or their resident representatives, that wound care would be changed to in facility wound care performed by a certified wound care nurse practitioner. He stated that no printed letters were posted to residents or their representatives. He stated that Resident #3's contact was contacted but not his RR, even though Progress Note review for Resident #3 revealed that facility staff spoke to the RR on 8/11/25 two days prior to the first wound care clinic appointments missed by the resident with no documentation of change in the plan of care that included setting or provider. The Administrator stated that the change was initiated despite strong opposition of MD #1 and MD #2. He confirmed that there was no reason that the residents could not have received care both at the wound care clinic and in the facility. The Administrator informed the State Agency (SA) that on 10/13/25 he had sent an email to the collaborating physician for Nurse Practitioner (NP) #1, who was MD #1 and to MD #2 for whom the NP also took call, and revoked her privileges in the facility due to a decision (that) is administrative and compliance-driven-designed solely to unify our clinical processes-and is not a reflection of individual performance. The Administrator reported that on 10/31/25 he sent a letter to the only two attending physicians that practiced in the facility as a formal notice of termination of admitting and attending privileges. He said that on 10/31/25 he had not identified compliance, safety or care concerns and that he had not used printed, verbal or electronic means to impart any concerns, issues or complaints to NP #1, MD #1 or MD #2. He stated that the decision was made to facilitate a change of direction for the facility.On 11/10/25 at 3:50 PM an interview with Resident #11, the Resident Council President, revealed the council met the last Tuesday of each month. She explained that anyone can request to attend the meetings if they feel they need to. She reported that no staff had attended any Resident Council Meeting and notified the council that the facility had changed Medical Directors or explained any reason why MD #1 or MD #2 or NP #1 may have their privileges at the facility revoked. She stated that she had not been notified personally regarding any changes or options for new medical personnel or procedures to see her attending physician of choice. She stated that if she had a choice, she would keep her current attending physician and not have to make an appointment and go to his office to see him.On 11/10/25 at 7:52 AM a telephone interview with MD #2 revealed he was the attending physician for eighteen (18) residents at the facility. He reported that MD #1 was the attending physician for twenty-three (23) residents. He reported that they had received an email on 10/13/25 from the facility administrator in which privileges for Nurse Practitioner (NP) #1 were revoked without cause or reason given. He stated that he had later received a printed, posted letter dated 10/31/25 that stated that his admitting and attending privileges in the facility were revoked effective 11/30/25 without any cause or reason given. He stated that he had never received any explanation for the reason behind the