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	08/21/2025

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 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, interviews, facility policy review and record review the facility failed to respect a resident's dignity, as evidenced by leaving a feeding pump exposed in a public area for one (1) of two (2) residents receiving Percutaneous Endoscopic Gastrostomy feedings. Resident #34.Findings Include:Record review of the facility policy Our Residents' Rights, reviewed 05/18/2021, revealed, .Right to a Dignified Existence: Be treated with consideration, respect, and dignity, recognizing each resident's individuality.On 08/19/2025 at 12:54 PM, during an observation Resident #35 was observed in the hallway by the hair salon door, with a peg tube formula flowing at 50 milliliters/hour (ml/hr). There was not a privacy covering over the feeding pump.On 08/20/2025 at 10:53 AM, Resident #34 was observed sitting on the front porch in her wheelchair with the peg feeding formula exposed and flowing. There was not a privacy cover on the feeding pump.On 08/20/25 at 10:56 AM, during an interview, the transportation aide stated Resident #34's feeding pump is always exposed. She stated the only time she has seen it covered is when the resident goes to a physician appointment.On 08/21/2025 at 1:59 PM, in an interview the Director of Nursing (DON) stated she had spoken to management about covering peg tube feedings and was told that they did not make a cover to keep the peg feeding bag from being exposed. She confirmed it should be covered and it's a dignity issue. She stated they will put something in place to cover it.A record review of Resident #34 admission Record revealed an admission date of 3/1/24 with diagnoses that included Dysphagia Oropharyngeal Phase and other developmental Disorders of speech and language.A record review of Resident #34's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/05/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicates Resident #34 was cognitively intact.

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 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. Based on observation, interviews and record review and facility policy review, the facility failed to follow the care plan while providing Percutaneous Endoscopic Gastrostomy (peg) tube care for one (1) of four (4) observations. Resident #34. Findings include: A review of the facility policy, Comprehensive Plan of Care revised 2/17/25, reveals, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality A record review of the Care Plan Report revealed a care plan Focus: The resident has an alteration in gastrointestinal status (PEG STATUS) . with an initiation date of 3/1/24.Interventions/Task.Clean peg site with NS (normal saline), pat dry, apply drain sponge . On 08/20/25 at 1:40 PM, in an interview with Licensed Practical Nurse (LPN) #4, who is responsible for the Minimum Data Set (MDS) and care plans, she stated that the care plan is used by all staff and informs them of the residents' needs. She emphasized that the best course of action is to follow the care plan and warned that residents may suffer serious consequences if it is not followed. On 08/20/2025 at 2:43 PM, during an observation of peg site care with LPN#2 wound care nurse, revealed LPN #2 cleaned the peg site and applied a dressing. She did not dry site prior to applying dressing. On 08/20/2025 at 4:10 PM, in an interview LPN #2, confirmed that she did not dry the peg site. She stated that she should have dried the site to prevent infection. She added that residents can experience skin irritation at the site if it is not dried before applying the dressing. On 08/21/2025 2:05 PM, in an interview with Director of Nursing (DON) stated LPN #2 should have dried the site to prevent the possibility of bacteria. It should be dried to prevent the site from harboring bacteria. She stated she expects staff to follow the care plan at all times. A record review of Resident #34's Care Profile revealed a physician order dated 8/20/25, Clean peg site with NS (normal saline), pat dry, apply drain sponge, change daily and monitor for s/sx (signs and symptoms) of infection. A record review of Resident #34 admission Record revealed an admission date of 3/1/24 with diagnoses that included Dysphagia Oropharyngeal Phase and other developmental Disorders of speech and language. A record review of Resident #34 Minimum Data Set (MDS) with Assessment Reference Date (ARD) 6/15/25 revealed a Brief Interview of Mental Status (BIMS) score of 15, which indicates Resident #34 is cognitively intact.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observations, interviews, record review, and facility statement review the facility failed to provide follow physician orders when providing peg site care for one (1) of two (2) residents who require peg site care. Resident #34. Findings Include:Record review of a typed statement on facility letterhead, undated, and signed by the Director of Nursing (DON) revealed We do not have a policy on peg care.During an observation on 08/20/2025 at 2:43 PM, revealed LPN #2 cleaned the peg site using a Q-tip with normal saline. She cleaned site back and forward three times in a circular motion without rotating Q-tip, then applied a dressing. She did not dry site prior to applying dressing.In an interview on 08/20/2025 at 4:10 PM, LPN #2 confirmed she did not rotate the Q-tips while cleaning the peg site and did not dry the peg site before applying the cover dressing. She stated she should have cleaned and dried the site as ordered by the physician. She stated Resident #34 could have skin irritation at the site due to not being dried before applying the dressing and get an infection from method she used cleaning the site.On 08/21/2025 2:05 PM, in an interview the Director of Nursing (DON) stated LPN #2 should have used a Q-tip, went around site one time and disposed of the Q-Tip. She should have used a new Q-tip each time. She stated it is done to prevent the spread of infection. The further stated the peg site should be dried to prevent the site from harboring bacteria.A record review of Resident #34's Care Profile revealed a physician order dated 8/20/25 Clean peg site with NS (normal saline), pat dry, apply drain sponge, change daily and monitor for s/sx (signs and symptoms) of infection.A record review of Resident #34 admission Record revealed an admission date of 3/1/24 with diagnoses that included Dysphagia Oropharyngeal Phase and other developmental Disorders of speech and language.A record review of Resident #34's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/5/25 revealed a Brief Interview of Mental Status (BIMS) score of 15, which indicated Resident #34 is cognitively intact.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and facility policy, the facility failed to ensure that respiratory care was provided in accordance with professional standards of practice for one (1) of (13) residents sampled. Resident #7. Specifically, an Oxygen in Use sign was not posted on Resident #7s door who was receiving oxygen therapy.Findings include:Record review of the facility policy Oxygen. revised 06/14/2023 revealed, .2c. Precautionary signs readable from five (5) feet must be maintained on the door or gate where oxygen is stored.On 08/19/2025 at 11:50 AM, during an observation, Resident #7 was seated in a wheelchair at his bedside receiving oxygen via nasal cannula at a flow rate of two (2) liters per minute. There was no Oxygen in Use signage on the door to alert staff and visitors of active oxygen therapy.On 08/18/2025 at 12:00 PM, during a follow-up observation, Licensed Practical Nurse (LPN) #3 confirmed that there was no Oxygen in Use sign posted. LPN#3 immediately posted the appropriate signage on the door and agreed that a sign should have been placed for safety. The Director of Nursing (DON) was also made aware at this time, of the lack of signage posted and agreed a sign should have been on the door for safety.A record review of the Telephone/Verbal Order Signature Details for order date range 5/18/25 to 6/27/25 revealed a physician's order dated 6/26/25 O2@ (at) 2L (liters) via NC (nasal cannula) as needed r/t (related to) SOB (shortness of breath)/COPD. A record review of the admission Record revealed the resident was admitted on [DATE] with diagnoses that included Other Specified Chronic Obstructive Pulmonary Disease (COPD), Acute and Chronic Respiratory Failure with Hypoxia, and unspecified Asthma, Uncomplicated.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and facility policy review the facility failed to ensure expired nutritional supplements were removed from a storage area for one (1) of (1) observation. Findings include:A review of the facility policy, Medication Storage revised [DATE] revealed . is the facility's policy . housed on our premises will be stored appropriately according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation and security .On [DATE] at 3:30 PM, an observation of the medication storage room, where the nutritional supplements were stored, conducted with Licensed Practical Nurse (LPN) #1 revealed (11) cartons of Med Pass 2.0 Fortified Nutritional Shake, (32) ounces each. Nine (9) cartons expired on [DATE], and two (2) expired on [DATE]. During this time, the State Agency (SA) interviewed LPN #1, who stated that all nurses are responsible for checking the storage room for expired items. She noted that administering expired Med Pass can cause stomach issues and may lead to hospitalization.At 2:06 PM on [DATE], during an interview, the Director of Nursing (DON) stated that night nurses are responsible for checking for expired items stored in the medication room. She explained that expired products could be spoiled and may cause gastrointestinal (GI) issues for residents who consume them.