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 _____	11/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 11/28/23 through 11/30/23. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid regulations for participation and cited regulatory deficiencies F600, F640, F645 and F758. Complaint Investigation (CI) MS#23082 was investigated related to Quality of Care/treatment, facility staffing and nurses services and the facility was found to be in compliance. A facility reported incident (FRI) CI MS#23341 was investigated related to resident abuse and the facility was found to not be in compliance and was cited F600. Census at the time of survey was 122 and the facility has beds for 130 residents.	F 000		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days	F 640		1/12/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/21/2023

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F 640	Continued From page 1 after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record reviews, and facility policy reviews the facility failed to transmit Annual and Quarterly Minimum Data Set (MDS) Assessments accurately and timely for two (2) of two (2) residents reviewed for MDS assessments. Resident #76 and Resident #101	F 640	F640 Statements contained herein are intended for purposes of compliance with Federal and State law regarding responses to the Statement of Deficiencies. The language herein is not intended to be used by any third party, it is	

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F 640	Continued From page 2 Findings include: Review of the facility policy titled, CH 5: Submission and Correction of the MDS Assessments dated October 2023 revealed, "When the transmission file is received by iQIES (Internet Quality Improvement and Evaluation System), the system performs a series of validation edits to evaluate whether or not the data submitted meet the required standards ...All error and warning messages are detailed and explained in the Error Messages guide ...5.2 Timeliness Criteria ...Encoding Data: ...For a comprehensive assessment (...Annual ..., encoding must occur within 7 days after the Care Plan Completion Date (V0200C2 + 7 days). For a Quarterly, Significant Correction to prior Quarterly, Discharge, or PPS assessment, encoding must occur within 7 days after the MDS Completion Date (Z0500B + 7 days) ..." A record review of the MDS 3.0 NH Final Validation Report for Resident #76 with a target date of 10/10/2023 revealed that the annual assessment had been rejected due to invalid skip patterns. The dates rejected were 10-24-2023, 10/30/2023, and 11/01/2023. A record review of the MDS 3.0 NH Final Validation Report for Resident #101 with a target date of 10/20/2023 revealed that the quarterly assessment had been rejected due to invalid skip patterns for dates of 10/30/2023 and 11/01/2023. An interview on 11/30/23 at 09:06 AM, the MDS nurse revealed that the annual MDS assessment for Resident #76 had an Assessment reference date (ARD) of 10/10/23 and was submitted on 10/24/23. She revealed the annual assessment	F 640	solely for the purposes of compliance with participation requirements of Medicare and Medicaid. 1. ~The Annual Minimum Data Set(MDS) Assessment for Resident #76 was resubmitted on 12/5/23 and accepted. ~The Quarterly MDS Assessment for Resident #101 was resubmitted on 12/18/23 and accepted. 2. All residents who meet the requirements for an Annual and Quarterly MDS Assessment have the potential to be at risk of this deficient practice. 3. ~The Administrator, Director of Nursing(DON), MDS Coordinator and Case Management Nurses reviewed the policy titled "CH:5 Submission and Correction of the MDS Assessments" on 12/6/23 with no revisions recommended. ~The MDS Coordinator will audit the validation reports weekly beginning 12/11/23 for 3 months to ensure submission of all assessments have been accepted. Negative findings will be addressed immediately. ~The Administrator held an in-service/education with the MDS Coordinator and Case Management Nurses on 12/6/23 to ensure the understanding that assessments must be	

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F 640	Continued From page 3 was rejected because of Section D inaccuracy and the annual assessment was unlocked and fixed and re-submitted on 10/30/23 the assessment was rejected again because of Section D inaccuracy. She revealed on 11/1/23 the annual was once again unlocked and fixed and at that time it was rejected because of Section O. She revealed at this time it is still rejected and she has not fixed and re-submitted. The MDS nurse revealed Resident #101's quarterly assessment was rejected because the residents Social Security number was put in inaccurately. She revealed it was a typo but now we are making sure we slow down when adding information to prevent that from happening again. She revealed a modification was submitted on 11/1/23 but was rejected due to inaccuracy again. She confirmed it is still not corrected and both Resident #76 and Resident #101 are on her to-do list for Monday. She revealed when an MDS is rejected she or the other MDS nurses look at the validation report. She confirmed the validation report identified the errors that were made on each submission. She confirmed they were not submitted accurately. She revealed the purpose of the MDS assessment is for reimbursement to the facility and to determine the development of clinical care plans based on interdisciplinary team assessments. A record review of the facility Record of Admission for Resident #76 revealed she was admitted to the facility on 12/22/2020. A record review of the facility Record of Admission for Resident #101 revealed she was admitted to the facility on 4/25/2023.	F 640	transmitted 14 days after the completion date and to also correct and resubmit any rejected assessments immediately. 4. ~The MDS Coordinator will report the findings of the audits and reviews to the Quality Assurance Committee beginning 1/11/24 and then on a monthly basis for 3 months. The Quality Assurance Committee can modify the plan, if needed, to ensure that the facility remains in compliance. ~The Administrator is responsible for the compliance of this corrective action and will monitor the validation report findings performed by the MDS Coordinator beginning 12/11/23 and then monthly for 3 months.	
F 645 SS=D	PASARR Screening for MD & ID	F 645		1/12/24

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F 645	Continued From page 4 CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission	F 645		

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F 645	Continued From page 5 to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review the facility failed to accurately complete a Pre-Admission Screening (PAS) for a resident with a mental disorder for one (1) of two (2) resident PASSARs (Pre-Admission Screening and Resident Review) reviewed. Resident #35 Findings Include:	F 645	F645 Statements contained herein are intended for purposes of compliance with Federal and State law regarding responses to the Statement of Deficiencies. The language herein is not intended to be used by any third party, it is solely for the purposes of compliance with participation requirements of Medicare and Medicaid.	

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F 645	Continued From page 6 Review of the facility policy titled, "Resident Assessment-Coordination with PASARR Program" with an implementation date of 07/10/23 revealed under the "Policy: This facility coordinates assessments with pre-admission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs..." Record review of Resident #35's "Record of Admission" revealed the resident was admitted to the facility on 3/3/23. Record review of Resident #35's "History and Physical" (Proper name of Health Services) dated 3/6/23 revealed the resident had a medical diagnoses history on admission of Bipolar Disorder. Record review of Resident #35's "Pre-Admission Screening" that was completed on 3/21/23 indicated the resident did not have any history of a mental illness. An interview on 11/29/23 at 2:00PM with Case Manager Nurse revealed that residents are discussed in their morning meetings regarding behaviors or new diagnoses. She stated that Resident #35 had a diagnosis of Bipolar Disorder when the Pre-Admission Screening was completed and the question regarding if the resident had a mental disorder should have been marked yes on the PAS that was completed on 3/21/23. She revealed that back in July of this year they had a staff meeting and discussed looking at these harder than we were, because it	F 645	1. On 11/29/23, a Mississippi Preadmission Screening and Resident Review (PASRR) Level II Change in Status Request form was completed and submitted to Maximus for Resident #35, identifying that the resident has a mental disorder with a diagnosis of Bipolar Disorder. On 11/30/23, the facility received a determination from Maximus that a need for a Level II PASRR is required. On 12/5/23, through the Level II screening performed with Resident #35, the Department of Mental Health deemed that Resident #35 is appropriate for nursing home level of care. 2. All residents with a mental disorder and individuals with intellectual disabilities could have the potential to be affected. 3. ~On 12/5/23, the Administrator, Case Management Nurses, and Social Services reviewed the facility policy titled "Resident Assessment-Coordination with PASRR Program" and no revisions were indicated. ~An in-service/education was conducted by the Administrator on 12/6/23 to ensure Case Management Nurses and Social Services department were educated on the process of accurately completing the PASRR referrals for any resident with a mental disorder or intellectual disability. ~All new admissions or current residents	

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F 645	Continued From page 7 was a bigger deal than we thought. An interview on 11/29/23 at 2:30 PM, with the Quality Assurance Nurse (QA) confirmed that the resident had a diagnosis of Bipolar Disorder when the residents PAS was completed, and the form was not filled out correctly because it indicated the resident did not have a mental disorder. Record review of Resident #35's Minimum Data Set with an Assessment Reference Date of 09/03/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 15, which indicates the resident is cognitively intact and in Section I that the resident had a diagnosis of Bipolar Disorder.	F 645	with a new mental disorder or intellectual disability or new psychotropic medication associated with a mental disorder or intellectual disability will be reviewed each morning in the Interdisciplinary Team Stand Up Meeting beginning 12/11/23 that is held routinely Monday - Thursday. Friday morning stand up meetings are held at the discretion of the Administrator. PASRR or Level II Change of Status Request Form will be completed and submitted to the State Designated Authority as required. 4. ~The Social Services and Case Management Director will audit all residents with a current mental disorder and/or intellectual disability to validate the accuracy of the PASRR referral. Audits began on 12/11/23 and will continue for the next 3 months. Negative findings will be addressed immediately. ~Beginning 12/11/23 and for the next 3 months, the Social Services Director will review the findings from the audits and report patterns/trends monthly in the Quality Assurance Performance Improvement(QAPI) Meeting beginning 1/11/24. The QAPI Committee will make recommendations as needed.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental	F 758		1/12/24

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F 758	Continued From page 8	F 758		

processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

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F 758	Continued From page 9 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to have a stop date on an "As Needed" (PRN) psychotropic medication for one (1) of three (3) residents reviewed for the use of psychotropic medications. Resident #58 Findings Include: Review of the typed statement on facility letterhead (undated) revealed the facility did not have a policy regarding a stop date for psychotropic medications and was signed by the Administrator. Record review of Resident #58's Physician's Orders revealed the following: Order dated 7/20/23-Lorazepam oral concentrate 2mg (milligrams)/1ml (milliliter) give 1ml every 2 (two) hours as needed for anxiety oral. An interview on 11/30/23 at 10:25 AM, with the Consultant Pharmacist revealed that any psychotropic medication that is PRN should have a stop date and that he had indicated on his 8/11/23 "Medication Regimen Review" for Resident #58 that he had relayed to the QA (Quality Assurance) nurse to check and make sure a stop date was on the PRN Ativan order that was written on 7/20/23. An interview and record review on 11/30/23 at 10:30 AM, with Registered Nurse (RN) #1	F 758	F758 Statements contained herein are intended for purposes of compliance with Federal and State law regarding responses to the Statement of Deficiencies. The language herein is not intended to be used by any third party, it is solely for the purposes of compliance with participation requirements of Medicare and Medicaid. 1. On 11/30/23, the Nurse Practitioner gave the order for a stop date of 12/4/23 for Ativan 2 mg/1 ml every 2 (two) hours as needed for anxiety for Resident #58. Resident #58 no longer has an as needed (PRN) psychotropic medication order. 2. ~All residents with a PRN psychotropic medication have the potential to be affected by this deficient practice. 3. ~The new policy titled "Psychotropic Medication Use Policy" was reviewed and approved by the Quality Assurance Committee on 12/12/23. The Medical Director reviewed and approved the said policy on 12/14/23. ~An in-service/education on F758 - "Free	

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F 758	Continued From page 10 revealed she is Resident #58's nurse and that she does have behaviors sometimes with increased anxiety. She confirmed that the resident had an order for Ativan scheduled one time per day and Ativan every 2 hours PRN. An interview on 11/30/23 at 10:47 AM, with the Director of Nurses (DON) confirmed that PRN psychotropic medications should have a stop date, because it may not be something they continue needing. She stated that if the PRN psychotropic medication was continued without a stop date, then it could cause the resident to be a fall risk. She confirmed that Resident #58's PRN Ativan order written on 7/20/23 did not have a stop date and that the Consultant Pharmacist's report from 8/2023 indicated that he had relayed to the QA nurse for her to check and make sure a stop date was put on that order. An interview on 11/20/23 at 11:00 AM with Family Nurse Practitioner (FNP) confirmed that she wrote the order for PRN Ativan on 7/20/23 and did not put a stop date on the order. She stated that she thought that with the resident being on hospice and her writing that she wanted the resident on the PRN Ativan indefinitely was ok. She revealed she understands that they need a stop date and review, and she would take care of that now. Record review of Resident #58's "Record of Admission" revealed the resident was admitted to the facility on 6/12/23. Record review of the History and Physical for Resident #58 dated 6/15/23 revealed medical diagnoses that included Dementia ...with mood disturbance, Generalized Anxiety Disorder and	F 758	from Unnecessary Psychotropic Meds/PRN Use" was held with all Licensed Practical Nurses (LPN) and Registered Nurses (RN) on 12/6/23 by the Pharmacy Consultant. All Full-time LPN and RN have been educated. All Part-time LPN and RN that were not in-serviced on the initial date will be educated prior to their next scheduled shift. ~All new PRN Psychotropic medications will be reviewed during the Interdisciplinary Stand Up Meeting beginning 12/11/23 each morning Monday - Thursday, to ensure that the order has a stop date. Friday morning stand up meetings are held at the discretion of the Administrator ~An audit was completed by the Nurse Practitioner on 12/6/23 of all residents who have an as needed (PRN) psychotropic medication order to determine if the PRN medication has a stop date included. No negative findings found during the audit. ~An audit was completed by the Pharmacy Consultant on 12/14/23 of all residents who have an as needed (PRN) psychotropic medication order to determine if the PRN medication has a stop date. No negative findings found during the audit. 4. ~The Director of Nursing (DON) and the Quality Assurance Nurses will audit all	

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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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 11 Major Depressive Disorder. Record review of Resident #58's Minimum Data Set with an Assessment Reference Date of 09/08/23 revealed in Section C a Brief Interview of Mental Status score of 07, which indicates the resident was severely cognitively impaired.	F 758	PRN Psychotropic Medication Orders weekly for 4(four) weeks, then monthly for 2 (two) months. Auditing will begin on 12/19/23. The results of these audits will determine the need for further monitoring. ~All audit information will be brought to the Quality Assurance Committee Meeting beginning 1/11/24 and then monthly by the Director of Nursing to be analyzed and reviewed.	