

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255160		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/03/2025	
NAME OF PROVIDER OR SUPPLIER DANIEL HEALTH CARE INC DBA THE MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 1905 SOUTH ADAMS STREET P O DRAWER 127, FULTON, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI) MS #2639213 at the facility on 11/3/25. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA investigated the complaint for accidents and cited F689. The census at the time of the survey was 126 with a bed capacity for 130 beds.			F0000			
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure the safety of a resident during a mechanical lift transfer and a resident sustained a forehead laceration requiring sutures for one (1) of four (4) residents sampled. Resident #1 Findings include: Record review of facility policy titled, "Total Lift Policy" with revision date of 2/2/17 revealed, "It is the policy of the facility that a total lift will be utilized as follows: by a licensed nurse or CNA (Certified Nursing Assistant) ... It requires two employees when lift is used..."			F0689			

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 reverse for further 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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F0689 SS = G	Continued from page 1 A phone interview with CNA #1 on 11/3/25 at 10:40 AM, revealed she was the CNA caring for Resident #1 when the lift incident occurred. She admitted that she transferred the resident without assistance and did not position the lift legs properly which caused the lift to tilt and the bar hit the resident on the forehead. She revealed "I tried to do it by myself, and it didn't go well". She acknowledged that some of the staff were in an in-service, but there were others available to assist, but she did not ask for help to move the resident. She acknowledged she had been in-serviced multiple times on lift safety and the requirement for two staff members to be present when a lift was used and she failed to follow this policy. She stated she had not done this before, and she knew she made a "big mistake and a bad judgement call" and was remorseful that because of her bad decision a resident was harmed and required stitches to her head. An observation on 11/3/25 at 11:30 AM revealed Resident #1 sitting in her geriatric chair in the day room. The laceration on her forehead was healed with an L-shaped scar visible that was approximately two inches long on vertical part and approximately one and one-half inch long on the horizontal part. During an interview on 11/3/25 at 3:10 PM, Registered Nurse (RN) #1 revealed she was the nurse supervisor when the incident occurred. CNA #1 came to her office and told her the resident's head was bleeding. When she arrived in the room, Resident #1 was in the geriatric chair still attached to the lift and her forehead was bleeding, so she held pressure to the wound. There were no other staff member in the room, so she asked CNA #1 if she used the lift by herself and she admitted she did. She stated she told CNA #1, "You know better than that. We always use two people". She revealed she notified the Nurse Practitioner (NP) who evaluated the resident and gave orders to send the resident to the Emergency Room (ER). On 11/3/25 at 4:00 PM, an interview with the Director of Nursing (DON) revealed CNA #1 had been in-serviced multiple times on lift safety which included the requirement to always use two (2) people and CNA #1 did not follow that procedure. Due to this, Resident #1 had a forehead laceration injury that required sutures. She acknowledged that it was her expectation for all staff to follow the policies of the facility to ensure residents' safety. She confirmed the facility failed to ensure the resident was free from injury by a staff member not following facility's policy related to lift use.			F0689			

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F0689 SS = G	Continued from page 2 During an interview on 11/3/25 at 4:05 PM, the Administrator revealed that it was her expectation that each staff member follow policies to safely meet the needs of each resident and CNA #1 failed to do that when she chose to use a lift for Resident #1 without assistance. This led to a forehead laceration that required sutures. She confirmed the facility failed to prevent an accidental injury to a resident by not properly using a lift for a resident's transfer. Record review of "Interdisciplinary Progress Notes" dated 10/9/25 at 10:09 AM, revealed. "This nurse was approached by CNA needing assistance in patient room due to head bleeding. When this nurse entered room resident noted sitting in Geri chair with Hoyer lift still attached to sling. A large laceration was noted to resident's right forehead. This nurse applied pressure to stop the bleeding and called for (proper name removed), DNP (Doctor of Nursing Practice) to come assess, treat. It appears resident head was struck on Hoyer lift during transfer." This note was signed by RN #1 Record review of Nurse Practitioner's "Interdisciplinary Progress Notes" dated 10/9/25 at 10:37 AM revealed, "... (proper name for Resident #1 removed) complains of pain to head and I have asked nursing staff to administer Tylenol. ... Orders given to transfer to (name of local hospital removed) ER for evaluation and management of the laceration. She will need Computed Tomography (CT) to determine any further injury..." Record review of "Interdisciplinary Progress Notes" dated 10/9/25 at 10:50 AM, revealed, "... Resident transferred to (proper name of hospital removed) via EMS (Emergency Medical Service) Ambulance Service." Record review of "Interdisciplinary Progress Notes" dated 10/9/25 at 3:40 PM, revealed, "Resident returned from (proper name of hospital removed) via ambulance. On assessment, resident noted to have dressing to forehead. Dressing removed and noted to have 11 stitches to laceration and dressing replaced..." Record review of "Physician Orders" revealed an order dated 8/6/25 for Tylenol 325 milligrams tablet two tablets every four hours as needed for pain. Record review of "Electronic Medication Record" revealed Tylenol was administered on 10/9/25 at 10:38 AM with reason of "grimacing d/t (due to) laceration on right forehead". Review revealed the resident received the Tylenol on 10/9/25 at 4:02 PM with reason of			F0689			

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F0689 SS = G	Continued from page 3 "grimacing with discomfort to right forehead r/t laceration". Record review of "Physician Orders" revealed an order dated 8/6/25 for Hydrocodone Bitartrate Acetaminophen 325-5 milligram tablet one tablet every four hours as needed for pain. Record review of "Electronic Medication Record" revealed Hydrocodone was administered on 10/10/25 at 8:39 PM due to "head pain". Review revealed Hydrocodone was administered on 10/11/25 with reason of "head pain". Record review of "Physician Orders" revealed an order dated 10/9/25 to send to hospital per ambulance for evaluation of laceration/contusion to right forehead. Record review of "Inservice Sign in Sheet" titled "In-service on New Slings for Total Lifts" dated 4/4/25 revealed CNA #1's signature. Record review of "In-Service Sign in Sheet" for "Lift check offs CNAs" revealed CNA #1's signature dated 5/15/25. Record review of "Inservice Sign in Sheet" titled "Lift Education Training for CNAs" dated 8/6/25 revealed CNA #1's signature for attending. Record review of "...Electric Patient Lift User Manual" revealed, "Safety Precautions ... Perform patient transfers with at least two caregivers present for added safety..." Record review of "Record of Admission" revealed the facility admitted Resident #1 on 8/6/25 with diagnosis listed as Alzheimer's Disease. Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/12/25 revealed a Brief Interview for Mental Status (BIMS) score of 99 which indicated the resident had severe cognitive impairment.	F0689					