

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                          |                            |                                                        |
|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255160</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/12/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DANIEL HEALTH CARE INC DBA THE MEADOWS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1905 SOUTH ADAMS STREET<br/>FULTON, MS 38843</b>                             |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 000                                                                             | <p>INITIAL COMMENTS</p> <p>The State Agency (SA) conducted an annual recertification survey at the facility from 08/08/2022 through 08/12/2022. The SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA cited deficiencies at F695 and F725 related to lack of registered nurse services for a resident with a tracheostomy.</p> <p>The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 08/10/2022, which began on 08/05/2022, when the facility failed to ensure qualified staff were present 24 hours per day to perform deep suctioning of a tracheostomy and other emergency procedures if needed, for Resident #26. Review of the Working Schedule, Staffing Grid and interviews revealed the facility did not have Registered Nurse or Respiratory Therapy coverage on 08/05/2022 and 08/06/2022, for three (3) shifts, which included 3 PM- 11 PM and 11 PM - 7 AM shifts. Resident #26 was diagnosed with an Acute Upper Respiratory Infection on 08/04/2022 with nebulizer treatments and antibiotics prescribed. Resident #26 had a diagnosis of Anoxic Brain Damage with a tracheostomy tube, with orders to suction the tube as needed for excessive secretions. The facility's failure to provide 24 hour per day services of an RN and/or RT, for possible deep suctioning and other emergency care of the tracheostomy tube was likely to cause, serious harm, serious injury, serious impairment, or death to Resident #26.</p> <p>IJ and SQC existed at:</p> | F 000                                                                      |                                                                                                                          |                            |                                                        |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/01/2022

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            |                                                                                                                          |                            |                                                        |
|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255160</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/12/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DANIEL HEALTH CARE INC DBA THE MEADOWS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1905 SOUTH ADAMS STREET<br/>FULTON, MS 38843</b>                             |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 000                                                                             | Continued From page 1<br>CFR(s): 483.25(i); Respiratory/Tracheostomy<br>Care and Suctioning (F695)<br><br>The SA notified the Administrator on 08/10/2022<br>of the IJ and SQC and provided an IJ Template.<br><br>The facility submitted an acceptable Removal<br>Plan on 08/11/2022, in which the facility alleged<br>all corrective actions were completed on<br>08/10/2022, and the IJ was removed as of<br>08/11/2022.<br><br>The SA validated the Removal Plan on<br>08/12/2022 and determined the IJ and SQC was<br>removed prior to exit. The scope and severity for<br>the IJ at CFR(s): 483.25(i);<br>Respiratory/Tracheostomy Care and Suctioning<br>(F695), was lowered to a "D" level, while the<br>facility develops and implements a Plan of<br>Correction (POC) and monitors the effectiveness<br>of the systemic changes to ensure the facility<br>sustains compliance with the regulatory<br>requirements. | F 000                                                                      |                                                                                                                          |                            |                                                        |
| F 695<br>SS=J                                                                     | Respiratory/Tracheostomy Care and Suctioning<br>CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including<br>tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who<br>needs respiratory care, including tracheostomy<br>care and tracheal suctioning, is provided such<br>care, consistent with professional standards of<br>practice, the comprehensive person-centered<br>care plan, the residents' goals and preferences,<br>and 483.65 of this subpart.                                                                                                                                                                                                                                                                                                                                                                                                                      | F 695                                                                      |                                                                                                                          | 9/7/22                     |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                            |                                                        |
|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255160</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/12/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DANIEL HEALTH CARE INC DBA THE MEADOWS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1905 SOUTH ADAMS STREET<br/>FULTON, MS 38843</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 695                                                                             | <p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, staff interview, facility policy review, Mississippi (MS) State Board of Nursing website review, and the Nurse Practice Act, the facility failed to ensure a Registered Nurse (RN) and/or Respiratory Therapist (RT) were scheduled for each shift to provide consistent respiratory care services, 24 hours each day to deep suction the tracheostomy (trach), if needed and /or provide other emergency care related to the trach, to a resident with a tracheostomy, for one (1) of 1 resident reviewed with a tracheostomy, Resident #26.</p> <p>During a review of the facility Staffing Grid, the facility did not have RN or RT coverage for the 11-7 shift on 08/05/2022 and there was not an RN assigned on the 3-11 shift and the 11-7 shift on 08/06/2022. Resident #26 had a diagnosis of Anoxic Brain Damage with a tracheostomy tube, with orders to suction the tube as needed for excessive secretions. Resident #26 was diagnosed with an Acute Upper Respiratory Infection requiring antibiotics and nebulizer treatments on 08/04/2022.</p> <p>The facility's failure to provide 24 hour per day services of an RN and/or RT, for possible deep suctioning and other emergency care of the tracheostomy tube was likely to cause serious harm, serious injury, serious impairment, or death to Resident #26.</p> <p>The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 08/10/2022, which began on 08/05/2022, when the facility failed to ensure qualified staff, a RN and/or RT, were present 24 hours per day to</p> | F 695                                                                      | <p>F695 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.</p> <p>1.<br/>Resident #26 continues to reside in this facility. Resident #26 was fully assessed on August 10, 2022 by the Nurse Practitioner at 7:42 P.M. with no acute findings or evidence of respiratory distress. Registered Nurse (RN) and/or Respiratory Therapist (RT) will be provided 24-hours each day for deep suctioning, if needed and/or provide other emergency care to render respiratory care services to a resident with a tracheostomy (trach).</p> <p>2.<br/>Any resident who resides or may reside at this facility with a trach has the potential to be affected by this deficient practice.</p> <p>3.<br/>*The "Suctioning Policy" was reviewed on August 10, 2022 by the Quality Assurance Committee with no changes made. (Please see attached "Suction Policy")<br/>*All Licensed Practical Nurses (LPN) and RN that have worked since August 10, 2022, have been in-serviced on the</p> |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                            |                                                        |
|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255160</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/12/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DANIEL HEALTH CARE INC DBA THE MEADOWS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1905 SOUTH ADAMS STREET<br/>FULTON, MS 38843</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 695                                                                             | <p>Continued From page 3</p> <p>perform deep suctioning of a Tracheostomy and other emergency procedures if needed, for Resident #26. The SA notified the Administrator on 08/10/2022 of the IJ and SQC.</p> <p>The facility submitted an acceptable Removal Plan on 08/11/2022, in which the facility alleged all corrective actions were completed on 08/10/2022, and the IJ was removed as of 08/11/2022.</p> <p>The SA validated the Removal Plan on 08/12/2022 and determined the IJ was removed prior to exit. The scope and severity for the IJ at CFR 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning, was lowered to a "D" level, while the facility develops and implements a Plan of Correction (POC) and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with the regulatory requirements.</p> <p>Findings include:</p> <p>Record review of the facility policy titled, "Suctioning Policy," revised May 28, 2018, revealed, "It is the policy of this facility to ensure that standards of best practice are consistent when upper airway suctioning is performed to remove secretions from the oropharynx, nasopharynx, or trachea ... Procedure ... 10. Tracheal suctioning ... d. If suctioning catheter needs to be inserted beyond the end of the tracheotomy tube (deep suctioning) this will be performed by an RN."</p> <p>Review of the Mississippi (MS) State Board of Nursing Laws and Rules Administrative Code Part 2830 Practice of Nursing Title 30:</p> | F 695                                                                      | <p>"Suction Policy", best practices and the scope of practice for deep suctioning by the Nurse Practitioner. In-services were complete on August 20, 2022.</p> <p>*RN staff have been educated on the facility attendance policy and the requirement that a RN on duty may not leave the facility until the on-coming RN has entered the facility.</p> <p>*RN staffing schedule will be reviewed in the Daily Stand-Up Meeting (Monday-Friday) with the Director of Nursing and/or Assistant Director of Nursing and the Administrator. Began date was August 15, 2022.</p> <p>*Administrator began reviewing daily RN time cards on August 10, 2022, and will continue to review for 3 months to ensure 24-hour RN coverage was met.</p> <p>Disciplinary action will be put into effect if protocol has not been followed or met.</p> <p>*RN Supervisors and Nurse Practitioner began to take on-call August 10, 2022 and will be assigned an on-call schedule to ensure RN coverage will be met for purposes of call-ins, schedule discrepancies, and/or emergency situations.</p> <p>*The Administrator began reviewing RN schedules on August 10, 2022 and will review RN schedules weekly in an effort to maintain appropriate 24-hour RN coverage.</p> <p>4.</p> <p>The results of the weekly review of RN schedules and staffing needs began on August 11, 2022 and will be reviewed every two (2) weeks for three (3) months</p> |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                            |                                                        |
|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255160</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/12/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DANIEL HEALTH CARE INC DBA THE MEADOWS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1905 SOUTH ADAMS STREET<br/>FULTON, MS 38843</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 695                                                                             | <p>Continued From page 4</p> <p>Professions and Occupations Chapter 2, Functions of the Licensed Practical Nurse, (LPN) revealed: Rule 2.1 LPN Supervision, "The LPN gives nursing care which does not require the specialized skill, judgement, and knowledge required of an RN, Advanced Practice Registered Nurse (APRN), Licensed Physician, or Licensed Dentist."</p> <p>Review of the MS State Board of Nursing (BON) website revealed frequently asked questions (FAQ's). The BON's statement regarding the LPN's scope of practice with Tracheostomy care revealed: "It is within the scope of practice of the LPN to perform Trach care and suction secretions from the Trach tube. However, it is not within the scope of practice for the LPN to perform deep right main stem suctioning. If deep suctioning is required for a patient, a Registered Nurse (RN) must perform the procedure."</p> <p>Record review of the assessment of Resident #26, completed by the Nurse Practitioner (NP) on 08/10/22, revealed, "He is currently being treated for Upper Respiratory Infection with Clindamycin 300mg (milligrams), four times daily since 8/4/22. A chest x-ray was obtained on 8/4/22 due to increased congestion, fever, and cough. In addition to the mentioned antibiotics, he routinely receives DuoNeb every six (6) hours (hr), scheduled, for congestion due to impaired respiratory function, Lasix 40mg twice daily for secretions, Zyrtec 10mg daily for secretions, Guaifenesin 100mg/5mg #20 milliliters (ml) every (q) 4hrs for secretions and Acetylcysteine 20% twice daily and as needed (PRN) for secretions. He has not required an as needed dose of Acetylcysteine since 8/4/22. He has an as needed order for Lasix 20mg intramuscular (IM) and</p> | F 695                                                                      | <p>during the Quality Assurance Performance Improvement (QAPI) meeting to ensure compliance and to identify any trends or patterns requiring further actions. The next QAPI meeting will be held September 7, 2022.</p> <p>*If compliance is not met in three (3) months, the Quality Assurance Performance Improvement committee will reevaluate the prior systems that are in place and make changes as needed. The committee will continue to review compliance for an extended three (3) months, meeting every two (2) weeks.</p> <p>*If compliance has been met during the three (3) months, compliance will then be reviewed every month during the Quality Assurance meeting.</p> |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                          |                            |                                                        |
|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255160</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/12/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DANIEL HEALTH CARE INC DBA THE MEADOWS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1905 SOUTH ADAMS STREET<br/>FULTON, MS 38843</b>                             |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 695                                                                             | <p>Continued From page 5</p> <p>received an as needed dose on 8/4/22, 8/7/222, and 8/9/22. He receives routine trach care and suctioning every shift and as needed. He has required as needed trach suctioning 8/4/22, 8/6/22, 8/8/22, and twice on 8/9/22 this month. Nurse report that his secretions have improved from green to yellow since receiving antibiotics. He has not required deep suctioning. No reports of apnea or labored breathing. He is afebrile and is no longer coughing."</p> <p>On 8/9/22, review of the "Staffing Grid" revealed there was not a RN assigned to the 11-7 shift on 8/5/22 and there was not a RN assigned on the 3-11 shift and the 11-7 shift on 8/6/22.</p> <p>An observation on 08/08/2022 at 12:30 PM, of Resident #26 revealed his tracheostomy with no visible secretions, the trach gauze was clean and secured at the base of the tracheostomy inner cannula. The observation revealed Resident #26 was receiving humidified air via trach collar, from a humidified air compressor. There was a covered suction machine and nebulizer set-up in the room. No visible signs of respiratory distress were noted. There were no audible breath sounds that would possibly indicate complications of breathing, and he was easily aroused by low tones.</p> <p>Record review of the "Record of Admission" revealed Resident #26 was admitted to the facility on 1/6/2006, with diagnoses that included Quadriplegia, Unspecified, Anoxic Brain Damage, Not Elsewhere Classified, Persistent Vegetative State, and Encounter for Attention to Tracheostomy.</p> <p>Record review of Resident #26's Quarterly</p> | F 695                                                                      |                                                                                                                          |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                          |                            |                                                        |
|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255160</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/12/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DANIEL HEALTH CARE INC DBA THE MEADOWS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1905 SOUTH ADAMS STREET<br/>FULTON, MS 38843</b>                             |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 695                                                                             | <p>Continued From page 6</p> <p>Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/18/2022, revealed Section C was not completed, due to question B0100, Comatose, of Section B of the MDS being answered, "yes," indicating, "persistent vegetative state/no discernible consciousness."</p> <p>On 08/09/2022 at 11:15 AM, a record review and an interview with the Administrator confirmed the Staffing Grid reflected there was not an RN assignment on the 11-7 shift on 08/05/2022 and there was no RN assignment on the 11-7 shift and the 3-11 shift on 08/06/2022. The Administrator revealed respiratory therapists are not employed in the nursing facility. The Administrator revealed the Nurse Practitioner (NP) was on call, as back-up RN coverage, for evenings, nights, and weekends, that she lived 5 minutes away from the nursing facility, and she could be called to come to the facility, in case of emergent tracheostomy care needs for Resident #26. The Administrator also revealed that she and the Director of Nursing (DON) were responsible for nurse scheduling. The Administrator confirmed she was aware of the need to have 24-hour a day RN coverage to ensure Resident #26 had qualified staff available, to reform deep suctioning or emergent trach care if the need should arise.</p> <p>An interview with the DON on 08/09/2022 at 11:30 AM, revealed she and the Administrator are responsible for nurse scheduling and that she normally had enough RNs to work every shift. She confirmed there was no RN coverage for the 11-7 shift on 08/05/2022 and on 08/06/2022. She also confirmed there was no RN coverage on the 3-11 shift on 08/06/2022. The DON also revealed the shifts were not covered on 08/05/2022 and</p> | F 695                                                                      |                                                                                                                          |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                          |                            |                                                        |
|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255160</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/12/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DANIEL HEALTH CARE INC DBA THE MEADOWS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1905 SOUTH ADAMS STREET<br/>FULTON, MS 38843</b>                             |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 695                                                                             | <p>Continued From page 7</p> <p>08/06/2022 because the assigned RN for the three (3) shifts called in on 08/05/2022 and 08/06/2022. She was unable to get the part-time RN to come to work, and could not find any other RN on staff to cover the shifts. The DON revealed she was responsible to come in and work an RN shift if she was not successful in finding other RN coverage. She did not come in to work the 3 shifts because it was an oversight on her part. The DON revealed back-up RN coverage assistance, for Resident #26, was available from the Nurse Practitioner, who was on call and could have been called from home if Resident #26 needed RN assistance for tracheostomy care on 08/05/2022 and 08/06/2022. She also stated the Assistant Director of Nursing (ADON) was used as back-up RN coverage when there was no staff RN to cover a shift. The DON revealed she had been having some scheduling conflicts, but not having 24-hour a day RN coverage was not a frequent occurrence. The DON confirmed she was aware that a resident with a tracheostomy required either an RN or an RT for deep suctioning.</p> <p>An interview with the ADON on 08/09/2022 at 12:45 PM, revealed she was not aware there was not 24-hour RN coverage on the nurse schedule for the 11-7 shift on 08/05/2022 and the 3-11 and the 11-7 shifts on 08/06/2022. She stated she was not available to cover the 3 shifts. The ADON confirmed she was one of the back-up RNs, if there was no staff RN available to work a scheduled evening, night, or weekend shift, but was always informed by the DON when she needed to work to ensure an RN was in the building 24-hours a day.</p> <p>In an interview with the DON on 08/09/2022 at</p> | F 695                                                                      |                                                                                                                          |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                          |                            |                                                        |
|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255160</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/12/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DANIEL HEALTH CARE INC DBA THE MEADOWS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1905 SOUTH ADAMS STREET<br/>FULTON, MS 38843</b>                             |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 695                                                                             | <p>Continued From page 8</p> <p>3:15 PM, she stated, "I am working with the RNs to try to provide 24-hour a day coverage. Scheduling has been hard. I can't get the day shift RNs to agree to work night shift and I have already worked a lot of extra shifts. Resident #26 has not had any respiratory problems in years and had not required deep suctioning in a very long time. He is stable and if he had any problems at night, the Licensed Practical Nurses, (LPNs) could call 911 and call me for help."</p> <p>On 08/10/2022 at 03:00 PM, an interview and a record review of the "Payroll Detail" sheets, with the Administrator, which documented all clock hour for RNs from 08/01/2021 through 08/07/2022, confirmed 24-hour RN coverage was not available in the nursing facility for 52 shifts. The Administrator stated she was not aware there had not been 24-hour a day RN coverage for this time period.</p> <p>An interview with the NP on 08/11/2022 at 09:30 AM, confirmed she was on call, for back-up RN coverage, when there was not an RN covering a shift on the weekends. She revealed she lived 10 minutes away from the nursing facility, and would come and clock in at the facility if she was called to work a shift. NP noted she had never been contacted by the DON or ADON to come and cover a shift other than for 08/05/2022 and 08/06/2022. She stated she was out of town on those days and was not able to come to the facility. The NP revealed she was only aware of the nursing facility's increased staffing issues with 24-hour a day RN coverage for the past two weeks. She agreed to be one of the back-up coverage RNs, for Resident #26, a long while ago, but could not remember exactly when she made the agreement with the Administrator and</p> | F 695                                                                      |                                                                                                                          |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                          |                            |                                                        |
|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255160</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/12/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DANIEL HEALTH CARE INC DBA THE MEADOWS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1905 SOUTH ADAMS STREET<br/>FULTON, MS 38843</b>                             |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 695                                                                             | <p>Continued From page 9<br/>DON.</p> <p>In an interview with the NP on 08/12/22 at 09:30 AM, she stated, "The resident is responding well to the antibiotics and other medications ordered for his Upper Respiratory Infection."</p> <p>Record review of the Physician Orders for Resident #26 revealed an order for Clindamycin Hydrochloride 300 milligrams (MG), four (4) times a day (QID) for (x) 10 days for an Upper Respiratory Infection and Congestion, with an order date of 08/04/2022 and a discontinue date (d/c) of 08/14/2022, Lasix 40 MG, at 12 noon, due to (D/T) Congestion, with an order date of 05/16/2018, Lasix 40 MG one tablet daily for congestion, with an order date of 5/16/2018, Zyrtec 10 MG Tablet, at 4 PM for Rhinitis/Secretions, with an order date of 5/16/2018, Guaifenesin 100 MG/5ML every 4 hours D/T thickened secretions, with an order date of 07/07/2022, Acetylcysteine 20% Solution Nebulizer Inhalation twice a day (BID) for secretions, with an order date 08/08/2022, Ipratropium Bromide-Albuterol Sulfate 3 MG/ 3 ML - 0.5 MG / 3 ML Inhalation every six hours (6), for Shortness of Breath (SOB) and Congestion Secondary to Impaired Respiratory Function, with an order date of 07/13/2021, Acetylcysteine 20% Solution one (1) ML everyday as needed (PRN), for increased secretions, with an order dated of 4/28/2022, and an order to suction tracheostomy PRN , dated 2/25/2020.</p> <p>Removal Plan:</p> <p>The facility submitted an acceptable Removal Plan on 08/11/2022 at 10:00 AM, in which the facility alleged all corrective actions were</p> | F 695                                                                      |                                                                                                                          |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                          |                            |                                                        |
|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255160</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/12/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DANIEL HEALTH CARE INC DBA THE MEADOWS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1905 SOUTH ADAMS STREET<br/>FULTON, MS 38843</b>                             |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 695                                                                             | <p>Continued From page 10</p> <p>completed 08/10/2022 and the IJ was removed on 08/11/2022. The SA validated the Removal Plan on 08/12/2022 and determined the IJ was removed on 08/12/2022, prior to exit.</p> <p>Review of the facility's Removal Plan revealed the facility took the following corrective actions to remove the IJ prior to exit:</p> <p>The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), on 08/10/22, when the facility failed to ensure qualified staff were present 24 hours per day to perform deep suctioning of a Tracheostomy and other emergency procedures if needed, for Resident #26.</p> <p>The facility Executive Director, the Administrator, the Director of Nursing, and the Assistant Director of Nursing were notified 8/10/2022 at 05:00 PM of Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) due to the facility failure to have a Registered Nurse or Respiratory Therapist available 24 hours per day, 7 days per week to provide deep suctioning in the event emergency care was needed. Resident #26 was admitted to the facility on 01/6/2006 with a tracheostomy. This placed Resident #26 at risk for serious injury, harm, impairment, or death. He was identified as the only resident with a tracheostomy.</p> <p>During the period of August 2021-August 2022 the staffing schedule and timecards revealed 52 days without 24 hour Registered Nurse or Respiratory Therapist coverage for the 3 PM -11 PM and 11 PM-7 PM shifts during the time frame of August 1, 2021 through August 7, 2022.</p> | F 695                                                                      |                                                                                                                          |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                          |                            |                                                        |
|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255160</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/12/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DANIEL HEALTH CARE INC DBA THE MEADOWS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1905 SOUTH ADAMS STREET<br/>FULTON, MS 38843</b>                             |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 695                                                                             | <p>Continued From page 11</p> <p>Facility Actions:</p> <p>Upon identification of a lack of Registered Nurse coverage on 08/10/2022 by the State Agency (SA), the Director of Nursing immediately verified Registered Nurse coverage for 08/10/2022 and going forward for each shift for tracheostomy needs for Resident #26.</p> <p>1. The Administrator discussed deficient findings with the Director of Nursing on 8/9/22 at 10:00 AM and verified lapse in coverage on specific shifts. The Director of Nursing immediately verified Registered Nurse coverage for 8/10/22 and going forward for each shift for deep suctioning and emergent tracheostomy care, if needed for Resident #26.</p> <p>2. The Medical Director, who is also the Attending Physician, was notified on 8/10/22 at 5:48 PM, of the Immediate Jeopardy, and the need for 24-hour coverage by a Registered Nurse or Respiratory Therapist by the Administrator.</p> <p>3. Resident #26 was fully assessed by the Nurse Practitioner on 8/10/22 and documentation signed off at 7:42 PM with no acute findings or evidence of respiratory distress.</p> <p>4. The comprehensive care plan and Physician Order for Resident #26 was reviewed and verified by the Director of Nursing to reflect the Registered Nurse will provide deep suctioning to the tracheostomy if needed per Physician orders on 8/10/22 at 7:45 PM.</p> <p>5. An emergency Quality Assurance (QA) Committee meeting was held on 8/10/22 at 6:00 PM, to review and revise, if needed, the facility</p> | F 695                                                                      |                                                                                                                          |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                          |                            |                                                        |
|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255160</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/12/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DANIEL HEALTH CARE INC DBA THE MEADOWS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1905 SOUTH ADAMS STREET<br/>FULTON, MS 38843</b>                             |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 695                                                                             | <p>Continued From page 12</p> <p>policy for tracheostomy suctioning which states that all Licensed Nursing Personnel or per State Nurse Practice Act/Respiratory Therapist is to be followed regarding tracheostomy suctioning. Policy has been reviewed and approved as current policy states that deep suctioning must be done by Registered Nurse. No changes to current policy were made. In addition, discussion was held regarding the need for 24-hour Registered Nurse or Respiratory Therapist coverage 7 days per week. Administration reemphasized the</p> <p>need for admission personnel to coordinate with the Administrator and/or Director of Nursing prior to the admission of a new resident who requires care exclusively by a Registered Nurse.</p> <p>The Director of Nursing will be responsible for ensuring 24-hour Registered Nurse or Respiratory Therapist coverage 7 days per week.</p> <p>Attendees: Owner, Administrator, Medical Director (via phone call), Director of Nursing, Nurse Practitioner, Assistant Director of Nursing, Education Coordinator (via phone call), Business office manager, Director of Social Services, Rehabilitation Social Worker, Receptionist, Rehabilitation Coordinator, 3 QA nurses, Clinical Nurse, Rehabilitation Director, Admission Coordinator, Minimum Data Set Coordinator, Minimum Data Set Nurse, Wound Nurse, Dietician, Dietary Manager.</p> <p>6. In-service education was initiated on 8/10/22 at 6:45 PM, by the Administrator and Nurse Practitioner, with all licensed Nursing Staff, regarding the need for a Registered Nurse or Respiratory Therapist coverage 24-hours per day</p> | F 695                                                                      |                                                                                                                          |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                          |                            |                                                        |
|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255160</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/12/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DANIEL HEALTH CARE INC DBA THE MEADOWS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1905 SOUTH ADAMS STREET<br/>FULTON, MS 38843</b>                             |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 695                                                                             | <p>Continued From page 13</p> <p>7 days per week as long as there is a tracheostomy resident in the facility. The Administrator and Director of Nursing emphasized the importance of working the full shift scheduled and not leaving early as this may cause a lapse in 24-hour coverage. The Director of Nursing is to be immediately notified of any schedule change to ensure coverage. No licensed nurse will be allowed to work until in-service education is completed to include new hires also. In-service will continue until all nursing staff has been educated on Suctioning policy and scope of practice for Licensed Practical Nurse and Registered Nurse. The facility policy for tracheostomy suctioning was reviewed as part of the in-service and education to ensure licensed staff understand the Mississippi Nurse Practice Act which requires deep suctioning to be performed only by a Registered Nurse or Respiratory Therapist.</p> <p>One-on-one in-service was held on 8/10/22 at 7:30 PM by the Administrator with the Director of Nursing and Assistant Director of Nursing who are responsible for scheduling all nursing personnel. The requirement for 24-hour Registered Nurse coverage for tracheostomy deep suctioning was thoroughly discussed and emphasized the importance of notifying the Administrator if there is a lapse in coverage.</p> <p>Validation:</p> <p>The SA validated the facility's Removal Plan on 08/12/2022:</p> <p>Facility Actions:</p> <p>1. The SA validated by record review and</p> | F 695                                                                      |                                                                                                                          |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                          |                            |                                                        |
|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255160</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/12/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DANIEL HEALTH CARE INC DBA THE MEADOWS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1905 SOUTH ADAMS STREET<br/>FULTON, MS 38843</b>                             |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 695                                                                             | <p>Continued From page 14</p> <p>interview, the Registered Nurse coverage on 08/09/2022, which the Director of Nursing implemented, for the Registered Nurse coverage for 08/09/2022 and going forward for each shift for tracheostomy needs for Resident #26.</p> <p>2. The SA validated by record review and interview, the Medical Director was notified on 8/10/2022 at 06:00 PM of the need for 24-hour coverage by Registered Nurse or Respiratory Therapist by the Administrator.</p> <p>The SA validated by record review and interview, the Medical Director and Attending Physician for Resident #26 was notified of the Immediate Jeopardy and Substandard Quality of Care at 06:00 PM on 08/10/2022 by the Administrator.</p> <p>3. The SA validated by record review, the comprehensive care plan for Resident #26 was reviewed and reflected the Registered Nurse will provide deep suctioning to the tracheostomy if needed per MD orders by the Director of Nursing on 08/09/2022 at 3:15 PM.</p> <p>4. The SA validated by interview and record review, Resident #26 was fully assessed by the Nurse Practitioner on 08/10/2022 and documentation signed off at 7:42 PM with no acute findings or evidence of respiratory distress.</p> <p>5. The SA validated by record review and interview; an emergency Quality Assurance Committee meeting was held 08/10/2022 at 06:00 PM to review the facility policy for tracheostomy suctioning which stated if suctioning catheter needs to be inserted beyond the end of the tracheotomy tube (deep suctioning) this will be performed by an RN. In addition, discussion was</p> | F 695                                                                      |                                                                                                                          |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                          |                            |                                                        |
|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255160</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/12/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DANIEL HEALTH CARE INC DBA THE MEADOWS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1905 SOUTH ADAMS STREET<br/>FULTON, MS 38843</b>                             |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 695                                                                             | <p>Continued From page 15</p> <p>held regarding the need for 24 hour Registered Nurse coverage 7 days per week.</p> <p>The Director of Nursing will be responsible for ensuring 24 hours Registered Nurse or Respiratory Therapist coverage 7 days per week.</p> <p>Attendees: Owner, Administrator, Medical Director (via phone call), Director of Nursing, Nurse Practitioner, Assistant Director of Nursing, Education Coordinator (via phone call), Business office manager, Director of Social Services, Rehabilitation Social Worker, Receptionist, Rehabilitation Coordinator, 3 QA nurses, Clinical Nurse, Rehabilitation Director, Admission Coordinator, Minimum Data Set Coordinator, Minimum Data Set Nurse, Wound Nurse, Dietician, Dietary Manager.</p> <p>6. The SA validated by record review and interview, in-service education was initiated on 08/10/2022 by the Nurse Practitioner with all licensed staff regarding the need for a Registered Nurse or Respiratory Therapy coverage 24 hours per day 7 days per week as long as there is a tracheostomy resident in the facility. The Director of Nursing is to be immediately notified of any schedule change to ensure coverage. No licensed nurse will be allowed to work until in-service education is completed to include new hires. The facility policy for tracheostomy suctioning was reviewed, as part of the in-service, to ensure licensed staff understood the Mississippi Nurse Practice Act which restricts deep right main stem suctioning to be performed only by a Registered Nurse or Respiratory Therapist. One-on-one in-service was held on 8/10/22 at 7:30 PM by the Administrator with the Director of Nursing and Assistant Director of</p> | F 695                                                                      |                                                                                                                          |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            |                                                                                                                          |                            |                                                        |
|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255160</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/12/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DANIEL HEALTH CARE INC DBA THE MEADOWS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1905 SOUTH ADAMS STREET<br/>FULTON, MS 38843</b>                             |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 695                                                                             | Continued From page 16<br><br>Nursing who are responsible for scheduling all nursing personnel. The requirement for 24-hour Registered Nurse coverage for tracheostomy deep suctioning was thoroughly discussed and emphasized the importance of notifying the Administrator if there is a lapse in coverage.<br><br>The SA validated all corrective actions were taken by the facility and the actions were completed as of 08/10/2022 and the IJ was removed on 08/11/2022, prior to exit on 08/12/22.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | F 695                                                                      |                                                                                                                          |                            |                                                        |
| F 725<br>SS=E                                                                     | Sufficient Nursing Staff<br>CFR(s): 483.35(a)(1)(2)<br><br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under | F 725                                                                      |                                                                                                                          | 9/7/22                     |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                            |                                                        |
|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255160</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/12/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DANIEL HEALTH CARE INC DBA THE MEADOWS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1905 SOUTH ADAMS STREET<br/>FULTON, MS 38843</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 725                                                                             | <p>Continued From page 17</p> <p>paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:<br/>Cross Reference F695</p> <p>Based on observation, staff interview, record review, Mississippi Board of Nursing Laws and Rules and facility policy review, the facility failed to provide qualified staff, a Registered Nurse (RN) and/or Respiratory Therapist (RT), 24 hours each day for 52 shifts from 08/26/2021 through 08/06/2022 to deep suction the tracheostomy (trach), if needed and/or provide other emergency care to render respiratory care services to a resident with a tracheostomy, for one (1) of 1 resident reviewed with a tracheostomy, Resident #26.</p> <p>Findings include:</p> <p>Record review of the facility policy titled, "Suctioning Policy," revised May 28, 2018, revealed, "It is the policy of this facility to ensure that standards of best practice are consistent when upper airway suctioning is performed to remove secretions from the oropharynx, nasopharynx, or trachea ... Procedure ... 10. Tracheal suctioning ... d. If suctioning catheter needs to be inserted beyond the end of the tracheotomy tube (deep suctioning) this will be performed by an RN."</p> <p>Review of the Mississippi (MS) State Board of Nursing Laws and Rules Administrative Code Part 2830 Practice of Nursing Title 30: Professions and Occupations Chapter 2, Functions of the Licensed Practical Nurse, (LPN)</p> | F 725                                                                      | <p>F725 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.</p> <p>1.<br/>Resident #26 continues to reside in this facility. Resident #26 was fully assessed on August 10, 2022 by the Nurse Practitioner at 7:42 P.M. with no acute findings or evidence of respiratory distress. Registered Nurse (RN) and/or Respiratory Therapist (RT) will be provided 24-hours each day for deep suctioning, if needed and/or provide other emergency care to render respiratory care services to a resident with a tracheostomy (trach).</p> <p>2.<br/>Any resident who resides or may reside at this facility with a trach has the potential to be affected by this deficient practice.</p> <p>3.<br/>*The "Suctioning Policy" was reviewed on August 10, 2022 by the Quality Assurance Committee with no changes made. (Please see attached "Suction Policy")</p> |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                            |                                                        |
|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255160</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/12/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DANIEL HEALTH CARE INC DBA THE MEADOWS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1905 SOUTH ADAMS STREET<br/>FULTON, MS 38843</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 725                                                                             | <p>Continued From page 18</p> <p>revealed: Rule 2.1 LPN Supervision, "The LPN gives nursing care which does not require the specialized skill, judgement, and knowledge required of an RN, Advanced Practice Registered Nurse (APRN), Licensed Physician, or Licensed Dentist."</p> <p>Review of the MS State Board of Nursing (BON) website revealed frequently asked questions (FAQ's). The BON's statement regarding the LPN's scope of practice with Tracheostomy care revealed: "It is within the scope of practice of the LPN to perform Trach care and suction secretions from the Trach tube. However, it is not within the scope of practice for the LPN to perform deep right main stem suctioning. If deep suctioning is required for a patient, a Registered Nurse (RN) must perform the procedure."</p> <p>An observation on 08/08/2022 at 12:30 PM, of Resident #26 revealed the resident had a tracheostomy with no visible secretions, the trach gauze was clean and secured at the base of the tracheostomy inner cannula. Resident #26 was receiving humidified air via trach collar, from a humidified air compressor, there was a covered suction machine and nebulizer set-up in the room, there were no visible signs of respiratory distress, there were no audible breath sounds that would possibly indicate complications of breathing, and he was easily aroused by low tones.</p> <p>Record review of the "Record of Admission" revealed Resident #26 was admitted to the facility on 01/06/2006, with diagnoses that included Quadriplegia, Unspecified, Anoxic Brain Damage, Not Elsewhere Classified, Persistent Vegetative State, and Encounter for Attention to</p> | F 725                                                                      | <p>*All Licensed Practical Nurses (LPN) and RN that have worked since August 10, 2022, have been in-serviced on the "Suction Policy", best practices and the scope of practice for deep suctioning by the Nurse Practitioner. In-services were complete on August 20, 2022.</p> <p>*RN staff have been educated on the facility attendance policy and the requirement that a RN on duty may not leave the facility until the on-coming RN has entered the facility.</p> <p>*RN staffing schedule will be reviewed in the Daily Stand-Up Meeting (Monday-Friday) with the Director of Nursing and/or Assistant Director of Nursing and the Administrator. Began date was August 15, 2022.</p> <p>*Administrator began reviewing daily RN time cards on August 10, 2022, and will continue to review for 3 months to ensure 24-hour RN coverage was met.</p> <p>Disciplinary action will be put into effect if protocol has not been followed or met.</p> <p>*RN Supervisors and Nurse Practitioner began to take on-call August 10, 2022 and will be assigned an on-call schedule to ensure RN coverage will be met for purposes of call-ins, schedule discrepancies, and/or emergency situations.</p> <p>*The Administrator began reviewing RN schedules on August 10, 2022 and will review RN schedules weekly in an effort to maintain appropriate 24-hour RN coverage.</p> <p>4.<br/>The results of the weekly review of RN</p> |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                            |                                                        |
|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255160</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/12/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DANIEL HEALTH CARE INC DBA THE MEADOWS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1905 SOUTH ADAMS STREET<br/>FULTON, MS 38843</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 725                                                                             | <p>Continued From page 19</p> <p>Tracheostomy.</p> <p>Record review of Resident #26's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/18/2022, revealed Section C was not completed, due to question B0100, Comatose, of Section B of the MDS being answered, "yes," indicating, "persistent vegetative state/no discernible consciousness."</p> <p>Record review of the Physician Orders for Resident #26 revealed an order to suction tracheostomy PRN (as needed), dated 2/25/2020.</p> <p>On 8/9/22, record review of the "Staffing Grid" revealed there was not an RN assigned to the 11-7 shift on 08/05/2022 and there was not an RN assigned on the 3-11 shift and the 11-7 shift on 08/06/2022.</p> <p>On 08/09/2022 at 11:15 AM, a review of the Staffing Grid and interview with the Administrator confirmed the Staffing Grid reflected there was not an RN assignment on the 11-7 shift on 08/05/2022 and there was no RN assignment on the 11-7 shift and the 3-11 shift on 08/06/2022. The Administrator stated that she and the Director of Nursing (DON) were responsible for nurse scheduling and there were no respiratory therapists employed by the nursing facility. The Administrator revealed the Nurse Practitioner (NP) was on call, as back-up RN coverage, for evenings, nights, and weekends, that she lived 5 minutes away from the nursing facility, and she could be called to come to the facility, in case of emergent tracheostomy care needs for Resident #26. The Administrator confirmed she was aware of the need to have 24-hour a day RN coverage, to ensure Resident #26 had qualified staff</p> | F 725                                                                      | <p>schedules and staffing needs began on August 11, 2022 and will be reviewed every two (2) weeks for three (3) months during the Quality Assurance Performance Improvement (QAPI) meeting to ensure compliance and to identify any trends or patterns requiring further actions. The next QAPI meeting will be held September 7, 2022.</p> <p>*If compliance is not met in three (3) months, the Quality Assurance Performance Improvement committee will reevaluate the prior systems that are in place and make changes as needed. The committee will continue to review compliance for an extended three (3) months, meeting every two (2) weeks.</p> <p>*If compliance has been met during the three (3) months, compliance will then be reviewed every month during the Quality Assurance meeting.</p> |                            |                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2022  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                          |                            |                                                        |
|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255160</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/12/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DANIEL HEALTH CARE INC DBA THE MEADOWS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1905 SOUTH ADAMS STREET<br/>FULTON, MS 38843</b>                             |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| F 725                                                                             | <p>Continued From page 20</p> <p>available, to perform deep suctioning or emergent trach care if the need should arise.</p> <p>On 08/09/2022 at 3:15 PM, in an interview with the DON she stated, "I am working with the RNs to try to provide 24-hour a day coverage. Scheduling has been hard. I can't get the day shift RNs to agree to work night shift and I have already worked a lot of extra shifts."</p> <p>An interview on 08/11/22 at 09:30 AM with the NP revealed she was only aware of the nursing facility's increased staffing issues with 24-hour a day RN coverage for the past two weeks. NP revealed she agreed to be one of the back-up coverage RNs, for Resident #26, a long while ago, but could not remember exactly when she made the agreement with the Administrator and DON.</p> <p>A record review of the facility 's "Payroll Detail" sheets from 08/01/2021 through 08/07/2022 confirmed RN coverage was not available in the nursing facility for 52 shifts from 08/01/2021 through 08/06/2022.</p> <p>An interview on 08/10/22 at 3:00 PM with the Administrator revealed she was not aware there had not been RN coverage for that many shifts in the past year.</p> | F 725                                                                      |                                                                                                                          |                            |                                                        |