MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38EM	A. BUILDING: _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINALD P WHITE NURSING FACILITY	1451 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted Complaint Investigations (CI) at the facility from 2/10/25 through 2/12/25. CI MS #27376 was investigated for Abuse, Pressure Sores, and Quality of Care and there were no deficiencies cited related to the complaint. CI MS #27588 was investigated for Abuse and Resident Left Soiled, and CI MS #27589 was investigated for Physical Abuse and Residents Rights. During the survey, the SA determined the facility was in compliance with the requirements Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. The SA cited M500 as Immediate Jeopardy (IJ) with Substandard Quality of Care (SQC) related to CI MS 27588 and CI MS 27589. Based on the facility's implementation of corrective actions on 1/7/25, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 1/8/25, prior to the SA's entrance on 2/10/25. On 12/31/24, Resident #1 was physically abused by facility staff, when a Certified Nurse Assistant (CNA), dragged the resident down the hallway, by his shirt, the collar and shoulder of his jacket into his room while License Practical Nurse (LPN) #1 observed and did not intervene or call for assistance. The facility did not follow their policies regarding abuse, reporting, and did not implement interventions from the residents' person-centered care plan. During the investigation, the SA identified an Immediate Jeopardy (IJ) and Substandard of Quality of Care (SQC) which began on 12/31/24 and existed at: Rule 45.17.2 - Resident Rights (M500) - Level IV The facility's failure to protect Resident #1 from	M 000		

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M 000	Continued From page 1 abuse placed this resident and all residents in a situation that was likely to cause serious injury, harm, impairment, or death. Additionally, the facility's failure to intervene placed other residents at risk of similar abuse due to systemic failures in abuse prevention. The SA notified the facility's Administrator of the IJ and SQC on 2/11/25 at 4:45 PM. Based on the facility's implementation of corrective actions on 1/7/25, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 1/8/25, prior to the SA's entrance on 2/10/25.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate	M 500		2/25/25

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M 500	Continued From page 2 medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion,	M 500		

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M 500	Continued From page 3 discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;	M 500		

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M 500	Continued From page 4 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level IV	M 500	This was past non compliance. No plan of	

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M 500	Continued From page 5 Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident's right to be free from physical abuse by a staff member for one (1) of three (3) sampled residents. Resident #1. Resident #1 was physically abused on 12/31/24 when a Certified Nurse Assistant (CNA) #1 dragged him by his shirt, the collar, and the shoulders of his jacket up the hallway into Resident #1's room. One nurse observed the abuse and failed to intervene, allowing the abuse to escalate. The facility's failure to protect Resident #1 from abuse placed this resident and all residents in a situation that was likely to cause serious injury, harm, impairment, or death. The situation was determined to be Immediate Jeopardy and Substandard Quality of Care (SQC) that began on 12/31/24. The State Agency (SA) notified the Administrator of the IJ and SQC on 2/11/25 at 4:45 PM. Based on the facility's implementation of corrective actions on 1/7/25, the SA determined the IJ and SQC to be Past-Non-Compliance (PNC) and the IJ was removed on 1/8/25. Findings include: A review of the facility policy titled "Suspicion of Abuse, Neglect, Exploitation, Injuries of Unknown Origin, And/or Misappropriation of Funds/Property To Individuals Receiving Services/Residents," revised January 2024, revealed, " ...It is the policy ...to affirm that all Individuals Receiving Services (IRS)/Residents have a right to be free	M 500	correction needed.	

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M 500	Continued From page 6	M 500		

from abuse ...Definitions ...Abuse: The willful infliction of physical pain, injury, or mental anguish, unreasonable confinement or the willful deprivation of services necessary to maintain physical and mental health ...Mental Abuse: includes ...humiliation, harassment ...Prevention ...(4) ...will review, correct, and intervene in situations in which allegations of abuse, neglect ...have potentially occurred ...D. Reporting: (1) All employees ...will immediately report any of the following (a) Witness of or discovery of any situation in which suspicion exits that an IRS/Resident has been the victim of abuse ..."

A record review of the "Investigative Summary Report", dated 1/7/25, revealed that on 12/31/24 at 2:21 PM, Resident #1 was dragged on the floor by CNA #1. The resident was assessed on 1/3/25 when the allegation was submitted, and the Director of Nurses (DON) was notified. It was reported on 1/3/25 that on 12/31/24, CNA #1 dragged Resident #1 on the floor by the neck of his shirt to his room because the resident positioned himself on the floor in the hallway near the nurse's station. The resident was observed lying on the floor, hitting his head, and refusing to keep his protective helmet on. The investigation into the allegation yielded evidence that CNA #1 did drag the resident by the neck and shoulder sections of his jacket up the hallway into his room. Staff were placed on administrative leave pending the investigation and following the investigation, CNA #1 and License Practical Nurse (LPN) #1 were terminated on 1/7/25.

A record review of LPN #1's written statement, dated 1/6/25, revealed that on 12/31/24 between 2:00 PM and 2:30 PM, Resident #1 was banging his head against the wall. CNA #1 proceeded to grab the resident by his neck and sweatshirt and

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M 500	Continued From page 7	M 500		

drag him to his room. She felt like she was choking him, and she felt like this was abuse. She reported to the security officer and attempted to notify her DON, but she was not in her office.

On 2/10/25 at 2:00 PM, during an observation and interview, Resident #1 was lying in his bed and sat up to speak during the interview. He confirmed that he remembered the CNA who dragged him down the hall. He stated that she did not hurt him but commented that she didn't have to drag him "like an old rag." Resident #1 explained that he was embarrassed by the CNA's actions. He reported that he often hits his head on the wall or the floor because he normally wants something and that is his way of getting attention from the staff, but on this day (12/31/24), he was dragged to his room by the CNA.

On 2/10/25 at 2:35 PM, in an interview with the Campus Safety Officer, he confirmed he was working on 12/31/24, but stated he did not witness the event. He explained that an LPN approached him on 12/31/24 and asked him generalized questions about physical abuse, but she did not inform him of the incident that had occurred. He advised her to inform her immediate supervisor if she had questions on the definition of physical abuse. He reported he was not aware of the incident until the investigation began on 1/3/25.

On 2/10/25 at 2:43 PM, during an interview with the Housekeeper, he confirmed that he witnessed Resident #1 being pulled by his clothing down the hall approximately 20 feet by a staff member. He stated he did not report the episode to his manager because he assumed the other staff would have reported it. Still, he was placed on

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M 500	Continued From page 8	M 500		

administrative leave following the episode and attended many in-services on reporting following the episode.

On 2/10/25 at 3:00 PM, during an observation of the surveillance video with the Administrator present, on 12/31/24 at 2:07 PM, CNA #1 was observed dragging/pulling Resident #1 by his arm/sleeve of his clothes, right side, approximately 16 feet to his room, and LPN #1 was observed walking beside the resident and the CNA.

On 2/11/25 at 12:01 PM, during an interview with Registered Nurse (RN) #1, she confirmed that on 1/3/25, LPN #1 informed her that CNA #1 pulled Resident #1 down the hallway on the floor by his clothes because he was banging his head on the floor. LPN #1 stated that she attempted to re-direct him and place his helmet on, but he refused the helmet. LPN #1 revealed she attempted to notify security and the DON of the incident, but the DON wasn't available, so she didn't report it until her next shift on 1/3/25. RN #1 confirmed that the facility's policy is to report any abuse to a supervisor, DON, or Administrator. RN #1 stated that LPN #1 and CNA #1 did not treat Resident #1 with respect or dignity.

On 2/11/25 at 12:30 PM, during an interview with CNA #2, she confirmed Resident #1 was her assigned resident on 12/31/24. She revealed that she witnessed CNA #1 drag the resident down the hallway but stated that she did not have time to intervene. She reported the event was over in just a few seconds. LPN #1 advised her that she was going to report the episode to security campus, so CNA #2 did not report the episode to any supervisor.

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M 500	Continued From page 9 On 2/11/25 at 1:00 PM, during a phone interview with CNA #1, she confirmed that she dragged Resident #1 down the hallway by his clothing. She said that Resident #1 was not her assigned resident, but he was sitting on the floor between two doors, and it was difficult for residents to get through the doorways. CNA #1 explained Resident #1 had had this behavior in the past to get attention, so she grabbed his clothes and pulled him about 20 feet to his room. She was not trying to do anything intentional to hurt him and she was not being vindictive, but he was hitting his head on the floor and the wall. CNA #1 confirmed that Resident #1 was not her assigned resident and she did not attempt to redirect him, nor offer him food or water. She explained that she just "responded", and she did not think of the outcome. CNA #1 expressed remorse and commented that she has been very upset since the incident. In an interview with the Administrator on 2/11/25 at 3:40 PM, he confirmed that upon reviewing the video surveillance, CNA #1 dragged Resident #1 by his shirt/jacket to his room. He stated that this incident was a form of physical abuse and that LPN #1, who was present, should have intervened to stop the situation. During an interview with the DON on 2/11/25 at 4:00 PM, confirmed that following a review of the video surveillance, CNA #1 did drag Resident #1 on the floor by his clothing down the hall and placed him in his room. A record review of the "Face Sheet," revealed the facility admitted Resident #1 on 8/7/24 with current diagnoses including Epilepsy, Bipolar Disorder, and Mild Intellectual Disabilities.	M 500		

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M 500	Continued From page 10 A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/5/24, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated his cognition was moderately impaired. Further review revealed his vision was severely impaired. The facility implemented the following Corrective Action Plan prior to the State Agency's entrance on 2/10/25: The Quality Assurance (Quality Assurance) Committee held an Emergency QA Meeting on 1/7/2025. The Quality Assurance Committee discussed the description of the incident. The QA committee discussed and approved training that was provided beginning on 1/3/25 at the beginning of the shift to all staff on Resident Rights, Suspicion of Abuse, Neglect, Exploitation, Injuries of Unknown Origin, and misappropriation of funds/Property to Individuals Receiving Services/Residents and Resident # 1 behavior Intervention protocol. The additional will be monitored per staff for continued effectiveness as follows: Abuse/Neglect Policy & Adherence to Care Plan. Quality of correction will also be monitored by observing interventions and interactions with patients 5 (five) days a week for 8 (eight) weeks by Nurse Manager and four Nurse Supervisor, beginning on 1/21/25. Findings will be reported to QAPI (Quality Assurance Performance Improvement), beginning 2/13/25 times two months.	M 500		

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M 500	Continued From page 11 On 1/3/25, all supervisors began training all the oncoming staff before the start of their shift on Resident Rights, Suspicion of Abuse, Neglect, Exploitation, Injuries of Unknown Origin, or Misappropriation of Funds/Property to Individuals Receiving Services/Residents, and Resident #1 Behavioral Intervention Protocol. No employee was allowed to work until there was in-service. On 1/3/2025 CNA #1 and License Practical Nurse (LPN)#1 were placed on administrative leave pending completion of the investigation. LPN #1 was terminated from employment on 1/7/25 for observing physical abuse and failing to report it in a timely manner. CNA #1 was terminated from employment effective 1/7/25 for physically abusing Resident #1. The Investigator notified the State Agency by telephone on 1/3/25, the Attorney General's Office in writing of the incident on 1/3/25. Supervisors began In-servicing all employees on 1/3/25 prior to the beginning their shift. The in-services were completed on 1/7/25. The facility alleges all corrective actions were completed on 1/7/25 and the IJ removed on 1/8/25 prior to the State Agency's entrance on 2/10/25. Validation: The SA validated on 2/12/25, through interview and record review, that all corrective actions had been implemented as of 1/7/25, and the facility was in compliance as of 1/8/25, prior to the SA's entrance on 2/10/25.	M 500		