STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A123	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINALD P WHITE NURSING FACILITY	**1451 NORTH LAKELAND DRIVE , MERIDIAN, Mississippi, 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) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI), MS #2607086, at the facility from 10/20/25 through 10/22/25. CI MS #2607086 was a facility reported incident (FRI) regarding a resident fall during a mechanical lift transfer. During the survey, the SA determined the facility was in compliance with the requirements for participation in Medicare and Medicaid and cited F600 and F656 based on the facility's implementation of corrective actions on 9/5/25. The SA determined the deficiencies to be Past Non-Compliance (PNC), prior to the SA's entrance on 10/20/25. The facility held a license for 70 beds, with a census of 66.	F0000		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure a resident's right to be free from neglect when two (2) staff members completed a resident transfer with a mechanical lift without using the required four (4) staff members	F0600	"Past Noncompliance - no plan of correction required"	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0600 SS = D	Continued from page 1 for resident safety, which resulted in the resident falling backward for one (1) of three (3) sampled residents. Resident #1. Findings include: A review of the facility's policy "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 from…neglect…Definitions…Neglect: The failure to supply an IRS with food, shelter, clothing, or other services necessary to maintain physical and mental health…" A record review of the "Face Sheet" revealed the facility admitted Resident #1 on 7/31/23 with diagnoses including Parkinson's Disease. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/25/25 revealed Resident#1 had a Brief Interview for Mental Status (BIMS) summary score of 09, which indicated her cognition was moderately impaired. A record review of the "Investigative Summary Report" revealed the date of the incident was 8/30/25 and the "Type of incident" was listed as "Staff violation of care plan/physician orders causing accident." A "Description of the Incident" indicated that on 8/30/25 at approximately 10:27 AM, Resident #1 sustained a fall in her bedroom. At the time of the fall Resident #1 was being transferred from the bed to a transport chair. Once Resident #1 was seated into the transport chair it fell backwards landing onto the floor. Resident #1 complained of her head hurting with no visible injuries noted. The resident was transferred to local emergency room for further medical evaluation. Investigation into this accident/incident showed that at the time of the event Resident #1 was being transferred using a Hoyer lift from her bed to a transport chair by two (2) CNAs. Resident #1 was care planned for a "four person assist" (three CNAs and one nurse). CNAs #1 and #2 were the only two employees conducting the bed to chair transfer, which violates the care plan/doctor's orders. They were both placed on administrative leave, pending investigation. A record review of CNA #1 signed statement dated 8/30/25 revealed she was aware of the 4 people assist for Resident #1 and stated "We have been short of staff and only 2 people has been assisting."	F0600		

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F0600 SS = D	Continued from page 2 A record review of CNA #2 signed statement dated 8/30/25 revealed, "…knew resident at the time was a 4 person assist, but when I went to a meeting, prior till this date, we all was told 2 person… was thinking 2 person assist from that meeting…" A record review of the facility's "…Hoyer Lift care plan failure" document revealed the facility had implemented corrective actions. On 9/2/25 and 9/5/25, the facility held a Quality Assurance (QA) committee meeting to discuss the incident. Training on Neglect and review of the manufacturer's instruction mechanical lift and transport chair was conducted immediately. Additional training was conducted by the Attorney General related to Resident Rights and Suspicion of Abuse, Neglect was conducted from 9/23/25 to 9/24/25. Disciplinary actions included both CNAs placed on administrative leave and terminated from employment. On 10/21/25 at 12:30 PM, during an interview with the Director of Nursing (DON), she confirmed that staff failed to provide the necessary care and supervision to ensure Resident #1's safety during a transfer. The DON stated that two Certified Nurse Assistants (CNAs) attempted to transfer Resident #1 using a mechanical lift without obtaining the additional assistance required to safely complete the procedure. She acknowledged that the resident's condition required more staff support due to physical limitations and risk for instability, and performing the transfer with only two CNAs did not meet the resident's needs and placed her at risk for injury. The DON stated that the incident may have been prevented if staff had followed established facility expectations for safe transfers. She emphasized that it is the facility's responsibility to ensure that staff provide necessary care and services to prevent neglect and protect resident safety. On 10/21/25 at 1:00 PM, during an interview with the Administrator, he confirmed that the facility maintained written policies addressing resident safety during transfers, proper use of mechanical lifts and transport chairs, and adherence to physician orders and care plans. The Administrator stated that all staff had been trained, and competencies validated on these procedures. He acknowledged that, despite adequate staffing and clear instructions requiring a four-person assist (three CNAs and one nurse) for Resident #1's transfers, two CNAs failed to obtain the additional assistance required to safely complete the transfer. The Administrator stated that this failure to provide necessary care and services placed the resident at risk	F0600		

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F0600 SS = D	Continued from page 3 for injury and constituted neglect, as staff did not ensure the resident's safety during the transfer. He verified that the facility immediately suspended and later terminated the two CNAs for failing to follow safety policies, initiated in-services for all nursing staff on proper mechanical lift use and resident supervision, and convened emergency Quality Assurance and Performance Improvement (QAPI) meetings on 9/2/25 and 9/5/25 to review the incident, reinforce policies, and prevent recurrence. The Administrator confirmed that the facility reported the incident to the State Agency and the Attorney General's Office within the required five (5)-day timeframe. On 10/21/25 at 1:30 PM, during a phone interview with CNA #1, she confirmed that she was asked by CNA #2 to assist in transferring Resident #1 into her transfer chair. CNA #1 revealed that following the transfer with the mechanical lift, the resident was seated upright in the chair when the chair flipped backward. She further reported that Resident #1 was normally transferred with three (3) CNAs and a nurse present; however, the CNA #2 told her that the protocol had recently been changed to only two (2) CNAs. Based on the facility's implementation of corrective actions on 9/5/25, the State Agency (SA) determined the deficiency to be Past Non-Compliance (PNC) and corrected as of 9/5/25, prior to the SA's first entrance on 10/20/25. Validation: The SA validated on 10/22/25 through interview and record review, that all corrective actions had been implemented as of 9/5/25 and the facility was in compliance, prior to the SA's entrance on 10/20/25.	F0600		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F0656	"Past Noncompliance - no plan of correction required"	

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F0656 SS = D	Continued from page 4 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to implement a comprehensive care plan interventions related to transferring a resident with a Hoyer (type of mechanical lift) for one (1) of three (3) residents reviewed for care plan implementation. (Resident #1) Findings include: A review of the facility's policy "Interdisciplinary Care Plan Team," dated August 2024, revealed, "…The purpose of the team is to define and coordinate the	F0656		

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F0656 SS = D	Continued from page 5 treatment for each resident…" A record review of the “Face Sheet” revealed the facility admitted Resident #1 on 7/31/23 with diagnoses including Parkinson's Disease. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/25/25 revealed Resident#1 had a Brief Interview for Mental Status (BIMS) summary score of 09, which indicated her cognition was moderately impaired. A record review of the “Physician Order Report” revealed Resident #1 had an order, dated 7/3/25 for “Transfer using Hoyer lift with 4 (four) person asst (assistance) to include nurse and 3 CNA’s…” A record review of the “Care Plan” revealed Resident #1 had a “Problem” of “Potential for Falls and an “Approach”, start date 1/28/2025, for “Transferred using Hoyer Lift with 4 (Four) Person Assist with Nurse and 3 CNAs…”. A record review of the “Investigative Summary Report” revealed the date of the incident was 8/30/25 and the “Type of incident” was listed as “Staff violation of care plan/physician orders causing accident.” A “Description of the Incident” indicated that on 8/30/25 at approximately 10:27 AM, Resident #1 sustained a fall in her bedroom. At the time of the fall Resident #1 was being transferred from the bed to a transport chair. Once Resident #1 was seated into the transport chair it fell backwards landing onto the floor. Resident #1 complained of her head hurting with no visible injuries noted. The resident was transferred to local emergency room for further medical evaluation. Investigation into this accident/incident showed that at the time of the event Resident #1 was being transferred using a Hoyer lift from her bed to a transport chair by two (2) CNAs. Resident #1 was care planned for a “four person assist” (three CNAs and one nurse). CNAs #1 and #2 were the only two employees conducting the bed to chair transfer, which violates the care plan/doctor’s orders. They were both placed on administrative leave, pending investigation. A record review of CNA #1 signed statement dated 8/30/25 revealed she was aware of the 4 people assist for Resident #1 and stated, “We have been short of staff and only 2 people has been assisting.” A record review of CNA #2 signed statement dated 8/30/25 revealed, “…knew resident at the time was a 4 person assist, but when I went to a meeting, prior till	F0656		

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F0656 SS = D	Continued from page 6 this date, we all was told 2 person… was thinking 2 person assist from that meeting…" A record review of the facility's "…Hoyer Lift care plan failure" document revealed the facility had implemented corrective actions. On 9/2/25 and 9/5/25, the facility held a Quality Assurance (QA) committee meeting to discuss the incident. Training on following the care plan guide was conducted immediately and disciplinary actions included both CNAs placed on administrative leave and terminated from employment. On 10/21/25 at 11:30 AM, an interview with Registered Nurse/MDS #1 revealed that care plans are individualized based on each resident's assessment, needs, and functional abilities. She revealed that the two CNAs involved in Resident #1's transfer did not follow the care plan, which required a four-person assist (three CNAs and one nurse) when using the Hoyer lift. She emphasized that it is her expectation that all licensed nurses and CNA's review and follow the resident's current care plan to ensure consistent, safe care and to prevent avoidable accidents. On 10/21/25 at 12:30 PM, during an interview with the Director of Nursing (DON), she revealed that staff did not follow the resident's comprehensive care plan when performing Resident #1's transfer using only two (2) CNA's, instead of the required three (3) CNA's and one (1) licensed nurse. The DON confirmed that the accident may have been prevented if the care plan interventions had been followed as written. She emphasized that it is the facility's expectation that all staff adhere to each resident's individualized care plan to ensure safety of the residents On 10/21/25 at 1:30 PM, a phone interview with CNA #1 confirmed that she was asked by CNA #2 to assist in transferring Resident #1 into her transfer chair. CNA #1 revealed that following the transfer with the Hoyer lift, the resident was seated upright in the chair when the chair flipped backward. She further reported that Resident #1 was normally transferred with three (3) CNAs and a nurse present; however, the CNA #2 told her that the protocol had recently been changed to two (2) CNAs. Based on the facility's implementation of corrective actions on 9/5/25, the State Agency (SA) determined the deficiency to be Past Non-Compliance (PNC) and the deficiency was corrected as of 9/5/25, prior to the SA's first entrance on 10/20/25. Validation:	F0656		

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F0656 SS = D	Continued from page 7 The SA validated on 10/22/25 through interview and record review, that all corrective actions had been implemented as of 9/5/25, prior to the SA's entrance on 10/20/25.	F0656		