Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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
M0000	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 Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M500. 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.	M0000		
M0500	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 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	M0500	"Past Noncompliance - no plan of correction required"	

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

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M0500	Continued from page 1 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, 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	M0500		

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M0500	Continued from page 2 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; 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	M0500		

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M0500	Continued from page 3 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 LICENSURE 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 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	M0500		

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M0500	Continued from page 4 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 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	M0500		

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M0500	Continued from page 5 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 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.	M0500		