| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 25A123 | A. Building<br>B. Wing | 02/12/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Reginald P White Nursing Facility | 1451 North Lakeland Drive<br>Meridian, MS 39307 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>41306<br><br>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.<br><br>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.<br><br>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.<br><br>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 and provided an IJ Template.<br><br>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.<br><br>Findings include:<br><br>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 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 .<br><br>(continued on next page) |

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.

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| Reginald P White Nursing Facility | 1451 North Lakeland Drive<br>Meridian, MS 39307 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 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.<br><br>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 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.<br><br>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.<br><br>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.<br><br>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 administrative leave following the episode and attended many in-services on reporting following the episode.<br><br>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.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Reginald P White Nursing Facility | 1451 North Lakeland Drive<br>Meridian, MS 39307 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>The facility implemented the following Corrective Action Plan prior to the State Agency's entrance on 2/10/25:<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Reginald P White Nursing Facility | 1451 North Lakeland Drive<br>Meridian, MS 39307 |

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|---|---|
| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 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.<br><br>The additional will be monitored per staff for continued effectiveness as follows:<br><br>Abuse/Neglect Policy & Adherence to Care Plan.<br><br>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.<br><br>Findings will be reported to QAPI (Quality Assurance Performance Improvement), beginning 2/13/25 times two months.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>Validation:<br><br>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. |

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|---|---|
| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>41306<br><br>Based on observation, interviews, record review, and facility policy review, the facility failed to implement its abuse policy, allowing an abusive act to occur without staff intervening or prompt reporting for one (1) of three (3) sampled residents. Resident #1.<br><br>Resident #1 was physically abused on 12/31/24 when Certified Nurse Assistant (CNA) #1 dragged him by his shirt, the collar, and the shoulders of his jacket up the hallway into Resident #1 room. One nurse observed the abuse and failed to intervene, allowing the abuse to escalate.<br><br>The facility's failure to implement abuse policies and protect Resident #1 from physical abuse and the facility's failure to intervene placed this resident and all residents in a situation that was likely to cause serious injury, harm, impairment, or death.<br><br>The situation was determined to be Immediate Jeopardy and Substandard Quality of Care (SQC). The State Agency (SA) notified the Administrator of the IJ and SQC on 2/11/25 at 4:45 PM and provided an IJ Template.<br><br>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.<br><br>Findings include:<br><br>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 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 .<br><br>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, CNA #1 and License Practical Nurse (LPN) #1 were terminated on 1/7/25.<br><br>(continued on next page) |

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|---|---|
| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 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 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 the Director of Nursing (DON), but she was not in her office.<br><br>During an observation and interview, on 2/10/25 at 2:00 PM, Resident #1 was lying in his bed. He confirmed that a CNA dragged him down the hall. He stated that it did not hurt 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.<br><br>During an interview on 2/10/25 at 2:35 PM, the Campus Safety Officer, 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.<br><br>During an interview on 2/10/25 at 2:43 PM, the Housekeeper confirmed that he witnessed Resident #1 being pulled by his clothing down the hall by a staff member. He stated he did not stop the situation because he felt it was not his place because there was a CNA and LPN present during the situation.<br><br>During an observation of the video surveillance with the Administrator on 2/10/25 at 3:00 PM, 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 CNA.<br><br>During an interview on 2/11/25 at 12:30 PM, CNA #2 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 CNA #2 that she was going to report the episode to security campus, so CNA #2 did not report the episode to any supervisor.<br><br>During a phone interview on 2/11/25 at 1:00 PM, CNA #1 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 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.<br><br>(continued on next page) |

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|---|---|
| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During 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, they were both educated on abuse prior to the incident.<br><br>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. LPN #1 should have stopped the physical abuse.<br><br>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.<br><br>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.<br><br>The facility implemented the following Corrective Action Plan prior to the State Agency's entrance on 2/10/25:<br><br>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.<br><br>The additional will be monitored per staff for continued effectiveness as it follows:<br><br>Abuse/Neglect Policy & Adherence to Care Plan.<br><br>Quality of corrections will be monitored daily by using a minimum of 5 (five) staff interviews per day 5 (five) days a week for 8 (eight) weeks by Nurse Manager and four Nurse Supervisors, beginning on 1/21/25.<br><br>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 Supervisosr, beginning on 1/21/25.<br><br>Findings will be reported to QAPI (Quality Assurance Performance Improvement), beginning 2/13/25 times two months.<br><br>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.<br><br>(continued on next page) |

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|---|---|
| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 1/3/2025 CNAs #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.<br><br>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.<br><br>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 Immediate Jeopardy was removed on 1/8/25. The facility alleges all corrective actions were completed on 1/7/25 and the Immediate Jeopardy was removed on 1/8/25 prior to the state department of health entrance on 2/10/25.<br><br>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.<br><br>Validation:<br><br>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. |

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| F 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>41306<br><br>Based on observation, interviews, record review, and facility policy review, the facility failed to report abuse in a timely manner for one (1) of three (3) sampled residents. Resident #1.<br><br>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 room. One nurse observed the abuse and failed to report it to the Director of Nursing (DON) or other staff.<br><br>The facility's failure to report Resident #1's abuse placed this resident and all residents in a situation that was likely to cause serious injury, harm, impairment, or death.<br><br>The situation was determined to be Immediate Jeopardy and Substandard Quality of Care (SQC) which 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 and provided an IJ Template.<br><br>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.<br><br>Findings include:<br><br>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 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 .<br><br>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 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.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 25A123 | A. Building<br>B. Wing | 02/12/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Reginald P White Nursing Facility | 1451 North Lakeland Drive<br>Meridian, MS 39307 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A record review of the Investigative Summary Report 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 investigation. Following the investigation, CNA #1 and License Practical Nurse (LPN) #1 were terminated on 1/7/25.<br><br>At 2:43 PM on 2/10/25, during an interview with the Housekeeper, he confirmed that he did not report the abuse he witnessed to his manager because he assumed the other staff would have reported it.<br><br>At 3:00 PM on 2/10/25, the SA observed 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 #1 and CNA #1.<br><br>At 12:01 PM on 2/11/25, during an interview with Registered Nurse (RN) #1, she confirmed that LPN #1 did not report that she had witnessed abuse of Resident #1 on 12/31/24 until 1/3/25, which was her next scheduled shift. RN #1 confirmed that the facility's policy is to immediately report any abuse to a supervisor, DON, or Administrator.<br><br>At 12:30 PM on 2/11/25, 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.<br><br>At 1:00 PM on 2/11/25, during a phone interview CNA #1, she confirmed she had dragged Resident #1 down the hallway by his clothing. CNA #1 stated that she did not report what had occurred on 12/31/24.<br><br>At 3:40 PM on 2/11/25, in an interview with the Administrator , he confirmed that staff should have reported the abuse of Resident #1 immediately when it occurred on 12/31/24.<br><br>At 4:00 PM on 2/11/25 during an interview with the DON, she confirmed the facility staff did not report the abuse of Resident #1 immediately and that it was not reported until 1/3/25. 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. She stated that facility staff should have reported it to administrative staff when it happened.<br><br>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.<br><br>(continued on next page) |

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| | 25A123 | A. Building<br>B. Wing | 02/12/2025 |

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|---|---|
| F 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 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.<br><br>The facility implemented the following Corrective Action Plan prior to the State Agency's entrance on 2/10/25:<br><br>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.<br><br>The additional will be monitored per staff for continued effectiveness as it follows:<br><br>Abuse/Neglect Policy & Adherence to Care Plan.<br><br>Quality of corrections will be monitored daily by using a minimum of 5 (five) staff interviews per day 5 (five) days a week for 8 (eight) weeks by Nurse Manager and four Nurse Supervisors, beginning on 1/21/25.<br><br>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.<br><br>Findings will be reported to QAPI (Quality Assurance Performance Improvement), beginning 2/13/25 times two months.<br><br>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.<br><br>On 1/3/2025 CNAs #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.<br><br>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.<br><br>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 Immediate Jeopardy was removed on 1/8/25. The facility alleges all corrective actions were completed on 1/7/25 and the Immediate Jeopardy was removed on 1/8/25 prior to the state department of health entrance on 2/10/25.<br><br>(continued on next page) |

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| | 25A123 | A. Building<br>B. Wing | 02/12/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Reginald P White Nursing Facility | 1451 North Lakeland Drive<br>Meridian, MS 39307 |

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| F 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 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.<br><br>Validation:<br><br>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. |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>41306<br><br>Based on interviews, record review, and facility policy review, the facility failed to implement comprehensive care plan interventions for a resident with behaviors for one (1) of three (3) sampled residents. Resident #1.<br><br>Resident #1 was physically abused on 12/31/24 when Certified Nurse Assistant (CNA) #1 dragged him by his shirt, the collar, and the shoulders of his jacket up the hallway into Resident #1 room. One nurse observed the abuse and failed to intervene, allowing the abuse to escalate.<br><br>The facility's failure to implement the care plan interventions placed this resident and all residents in a situation that was likely to cause serious injury, harm, impairment, or death.<br><br>The situation was determined to be an Immediate Jeopardy (IJ) that began on 12/31/24. The State Agency (SA) notified the Administrator of the IJ on 2/11/25 at 4:45 PM and provided an IJ Template.<br><br>Based on the facility's implementation of corrective actions on 1/7/25, the SA determined the IJ 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.<br><br>Findings include:<br><br>A review of the facility policy titled Interdisciplinary Care Plan Team, with a reauthorized date of August 2024, revealed, .The purpose of the team is to define and coordinate the treatment for each resident .<br><br>A record review of the Care Plan revealed, .Problem Onset 8/31/24: Potential For Mood and Behavioral Problem . with a goal of Resident will not have increased and mood behavior problem during the quarter, 5/3/25.Approaches: Resident to wear helmet at all times when out of bed for safety (D/T) due to hitting head on floors/walls. Redirect resident if he has inappropriate behaviors and involve him in activities .<br><br>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.<br><br>(continued on next page) |

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| | 25A123 | A. Building<br>B. Wing | 02/12/2025 |

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|---|---|
| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 2/11/25 at 10:09 AM, during an interview Registered Nurse (RN)/Minimum Data Set (MDS), she confirmed that she expects all staff to follow the Comprehensive Care Plans' interventions for residents. The care plans are person-centered and address residents' needs and safety. She explained that care plans are accessible to staff through care plan books at each nursing area and are reviewed periodically. The MDS nurse reported that in-service training is provided to the staff regarding following care plans, but acknowledged that some staff may not consistently follow them and disciplinary action is taken when necessary.<br><br>During an interview with the Director of Nursing on 2/11/25 at 4:00 PM, it was revealed that the unit staff should have followed the care plan interventions for the safety of Resident #1. She expected all staff to follow the residents' care plans, which are designed to provide each resident with care based on their individual needs. The DON acknowledged that Resident #1 has a documented history of self-injurious behavior (hitting his head on walls and floors), which is why he wears a helmet for protection. She confirmed that the resident's care plan includes redirection techniques, such as offering snacks, drinks, or engaging him in activities when he exhibits such behavior. She agreed that if these interventions had been implemented, the incident may have been prevented.<br><br>On 2/11/25 at 1:00 PM, during a phone interview with CNA #1, she reported that Resident #1 was not her assigned resident, so she did not follow the care plan on re-directing him, she just responded by dragging him to his room.<br><br>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.<br><br>A record review of the 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.<br><br>The facility implemented the following Corrective Action Plan prior to the State Agency's entrance on 2/10/25:<br><br>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.<br><br>The additional will be monitored per staff for continued effectiveness as it follows:<br><br>Abuse/Neglect Policy & Adherence to Care Plan.<br><br>Quality of corrections will be monitored daily by using a minimum of 5 (five) staff interviews per day 5 (five) days a week for 8 (eight) weeks by Nurse Manager and four Nurse Supervisors, beginning on 1/21/25.<br><br>(continued on next page) |

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|---|---|
| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 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.<br><br>Findings will be reported to QAPI (Quality Assurance Performance Improvement), beginning 2/13/25 times two months.<br><br>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.<br><br>On 1/3/2025 CNAs #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.<br><br>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.<br><br>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 Immediate Jeopardy was removed on 1/8/25. The facility alleges all corrective actions were completed on 1/7/25 and the Immediate Jeopardy was removed on 1/8/25 prior to the state department of health entrance on 2/10/25.<br><br>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.<br><br>Validation:<br><br>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. |