Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A123	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER
Reginald P White Nursing Facility

STREET ADDRESS, CITY, STATE, ZIP CODE
1451 North Lakeland Drive
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 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure services provided by the nursing facility meet professional standards of quality.

Based on observation, staff interview, record review, and policy review, the facility failed to ensure nursing services were provided in accordance with professional standards of practice by not verifying Percutaneous Endoscopic Gastrostomy (PEG) placement prior to administering medications for one (1) of four (4) residents observed for medication administration. Resident #13.

Findings included:

A review of the facility's policy titled Tube Enteral Nutrition, revised 10/24, revealed, The purpose of this protocol is to establish general guidelines for the use of tube enteral feedings for residents/Individuals Receiving Services (IRS) with a functioning Gastrointestinal Tract .

On 5/29/25 at 9:23 AM, during an observation of medication administration via PEG tube, Registered Nurse (RN) #2 administered MiraLAX, potassium chloride, and ibuprofen to Resident #13 without verifying PEG tube placement prior to administration.

On 5/29/25 at 10:40 AM, during an interview, RN #2 confirmed she had not verified PEG tube placement before administering medications. RN #2 acknowledged that placement verification is necessary to ensure the tube is in the correct position and stated that medications delivered into the body cavity could lead to complications.

On 5/29/25 at 1:40 PM, during an interview with the acting Director of Nursing (DON), she stated that RN #2 should have verified PEG tube placement prior to medication administration. The DON confirmed that failure to verify placement could result in complications

A record review of the Face Sheet revealed the facility admitted Resident #13 on 8/5/24.

A record review of the Physician Order Report revealed Resident #13 had diagnoses including Gastrostomy Status. Further review revealed Resident #13 had Physician Orders for Pro-Stat via PEG tube two (2) times daily (start date of 8/15/24); Potassium Chloride liquid 20 milliequivalent (mEq)/15 milliliter (mL), 15 mL via PEG tube daily (start date of 1/23/25); Ibuprofen suspension 100 milligrams (mg)/5 mL, 30 mL per tube; oral tube twice daily (start date of 9/18/24); MiraLAX powder 17 grams per PEG tube (start date of 8/9/24).

A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/2/25 revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of eleven (11), which indicated the resident's cognition was moderately impaired.

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

TITLE

(X6) DATE

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review, staff interview, and facility policy review, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to sustain corrective actions to prevent recurrence of previously cited deficiencies, specifically, the facility was cited for failing to maintain infection control practices during an annual recertification survey on 1/11/2024 and was cited again for the same deficiency during the current survey, demonstrating that QAPI failed to sustain ongoing monitoring and oversight to prevent recurrence for one (1) of three (3) deficiencies cited. (F880) Findings Include: A review of the facility's Quality Assurance document (undated) revealed, .The Outcome Services Division will .Periodically assess information based on established indicators, taking action to solve problems and pursue opportunities to improve quality . Record review of the Provider History Profile revealed the facility received a citation for F880-Infection Prevention & Control for the survey date of 1/11/2024. Record review of the CMS-2567 (a record that identifies the federal regulation in violation and describes the findings of noncompliance and the facility's plan of correction), with a survey date of 1/11/2024, revealed the facility received a citation for F880, .Based on observation, staff interviews, record review, and facility policy review, the facility failed to prevent the possibility of the spread of infection . during wound care for one (1) of five (5) wounds observed . During the current recertification survey, the facility failed to ensure staff followed appropriate infection prevention and control practices for two (2) of 18 sampled residents, Resident #13 and Resident #45. Specifically, the facility failed to ensure Registered Nurse (RN) #2 performed hand hygiene and donned appropriate personal protective equipment (PPE) while administering medications through a Percutaneous Endoscopic Gastrostomy (PEG) tube for Resident #13 who required enhanced barrier precautions (EBP) and failed to ensure Licensed Practical Nurse (LPN) # 1 followed EBP and glove-changing protocols during wound care for Resident #45. On 05/29/25 at 2:43 PM, in an interview, the Nursing Home Administrator (NHA) confirmed he was aware that during the prior annual survey, a Licensed Practical Nurse (LPN) was cited for failure to perform hand hygiene during wound care. He stated that since the prior citation, nurses had been retrained, and QAPI had focused on correcting the issue. He stated that QAPI meets monthly and that after three months of focused wound policy correction and achieving what they considered 100% compliance, the QAPI committee shifted focus to other issues. He further stated that follow-up may now occur only one to two times per year. He acknowledged that recent in-services focused on infection control had been conducted in the past few months.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff followed appropriate infection prevention and control practices for two (2) of 18 sampled residents, Resident #13 and Resident #45. Specifically, the facility failed to ensure Registered Nurse (RN) #2 performed hand hygiene and donned appropriate personal protective equipment (PPE) while administering medications through a Percutaneous Endoscopic Gastrostomy (PEG) tube for Resident #13 who required enhanced barrier precautions (EBP) and failed to ensure Licensed Practical Nurse (LPN) # 1 followed EBP and glove-changing protocols during wound care for Resident #45. The scope/severity for F880 was increased to E due to previous citation on the annual recertification survey on 1/11/24. Findings included: A review of the facility's Enhanced Barrier Precautions Protocol (undated), revealed, 1. Enhanced Barrier Precautions (EBP) are required for certain resident categories .3. For residents for whom EBP is indicated, EBP is employed when performing the following high-contact resident care activities .Device care or use . feeding tube .Wound care: any skin opening requiring a dressing . A review of the facility's policy, Hand Hygiene, revised 9/23, revealed: It is the policy .that employees will use proper hand hygiene techniques to prevent the spread of infectious diseases . Procedure .C. Employees must always wash hands .(4) Before performing invasive procedures .(7) Before and after touching wounds. (8) After removing gloves . Resident #13 On 5/29/25 at 9:23 AM, during an observation of a medication pass for Resident #13, RN #2 administered medications via a PEG tube. RN #2 wiped down the bedside table with an antibacterial wipe while wearing gloves, then removed her gloves without performing hand hygiene. She applied a new set of gloves, placed a barrier on the bedside table, removed her gloves again, and applied a second clean pair without hand hygiene. She failed to don a gown at any point during the procedure, despite the resident requiring EBP. On 5/29/25 at 10:40 AM, during an interview, RN #2 stated she should have performed hand hygiene initially and between glove changes. She also stated she should have worn a gown to protect the resident from potential contamination. She acknowledged these failures put the resident at risk for infection and noted she had received prior training on hand hygiene and EBP but forgot to follow protocol. On 5/29/25 at 11:05 AM, during an interview, RN #3, the Infection Preventionist stated nurses are expected to perform hand hygiene before starting care and between glove changes. She stated that gowns should be worn before initiating care under EBP protocols and confirmed that failure to do so could lead to infection. She stated staff received recent training on hand hygiene and EBP. On 5/29/25 at 1:40 PM, during an interview, the Acting Director of Nursing (DON) confirmed that RN #2 should have worn a gown before starting care and performed hand hygiene between glove changes. She stated the nurse could have used hand sanitizer or washed her hands, and that failing to do so risked transmitting germs or bacteria to the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the Face Sheet revealed the facility admitted Resident #13 on 8/5/24. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/2/25 revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated her cognition was moderately impaired. A record review of the Physician Order Report for 5/1/25 through 5/31/25 revealed Resident #13 had diagnoses including Gastrostomy status and had medications required to be administered via a PEG tube. Resident #45 On 5/28/25 at 12:58 PM, LPN #1 was observed performing wound care for Resident #45. Prior to initiating care, she failed to don a gown, despite the resident being on EBP. During the procedure, she cleansed a dirty wound bed and then applied a new dressing without removing or changing her gloves, thereby applying the clean dressing with contaminated gloves. On 5/28/25 at 1:35 PM, during an interview, LPN #1 acknowledged that she should have worn a gown and changed gloves during the wound care procedure to prevent infection. She confirmed that the resident was on EBP, and her actions did not follow protocol. On 5/28/25 at 1:38 PM, during an interview, the DON confirmed that LPN #1 should have worn a gown before entering the room and should have changed gloves during the procedure. She stated gowns were available in the room and that failure to change gloves risked spreading infection. A record review of the Nurse Competency Skill Assessment for Wound Care revealed that gloves should be removed, and clean gloves donned four times during wound care-specifically after cleansing a dirty wound and before applying a new dressing, in accordance with physician orders and manufacturer instructions. On 5/29/25 at 1:08 PM, during an interview, the facility's Infection Preventionist (IP Nurse) stated that LPN #1 should have worn a gown and changed gloves prior to applying the new dressing. She stated failure to do so contaminated the dressing and placed the resident at risk of infection. A record review of the Face Sheet revealed the facility admitted Resident #45 on 12/21/22. A record review of the Physician Order Report revealed Resident #45 had diagnoses including Venous Insufficiency and had a treatment with a start date of 4/25/25 to .Venous wound left anterior superior lower leg: Clean with normal saline, pat dry, apply Xeroform gauze and cover with dry dressing daily and PRN (as needed) . A record review of the Quarterly MDS with an ARD of 4/11/25 revealed Resident #45 had a BIMS score of three (3), which indicated his cognition was severely impaired.