

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 08/13/2026	
NAME OF PROVIDER OR SUPPLIER REGINALD P WHITE NURSING FACILITY				STREET ADDRESS, CITY, STATE, ZIP CODE 1451 NORTH LAKE LAND 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		M0000				
M0640	The State Agency (SA) conducted an annual re-licensure survey at the facility from 08/11/26 to 08/13/26. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M640. 45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to implement effective, individualized interventions to reduce the risk of accidents and injury for a resident with known behaviors of placing himself on the floor and routinely refusing a physician-ordered protective helmet, resulting in an unwitnessed fall with facial lacerations and an open nasal fracture, for one (1) of two (2) residents reviewed for accidents. (Resident #25). Findings include: A record review of the facility's policy titled, "Fall Prevention/Reduction Program," revised September 2020, revealed, "... It is the policy of (Proper Name) ... to decrease falls and the potential for falls of individuals receiving services residents through assessment, re-assessment, post-fall assessment and interventions to prevent a fall or the recurrence of a fall. Establish processes to ensure a safe therapeutic environment by assessing all ... residents to identify and address personal and/or environmental risk factors that might predispose them to falls and to take appropriate measures to mitigate those factors ... Prevention of falls is the responsibility of every employee ... Ensure that the residents treatment/care plan guide reflect the interventions that ... employees should be aware of		M0640				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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M0640	Continued from page 1 so as to aid in preventing falls..." A record review of Resident #25's "Accident/Incident Report Form" dated 08/08/2026 revealed the resident was found lying on the floor and sustained a small laceration to the bridge of the nose, a small laceration below the left eyebrow, and an abrasion to the left knee. Interventions documented following the incident included 15-minute safety checks. A record review of Resident #25's "Allegation Hand Off Form" dated 08/10/2026 revealed the facility identified the 08/08/2026 incident as an unwitnessed fall. The resident was transported to the hospital on 08/10/2026, and the hospital after-visit summary identified a diagnosis of an open fracture of the nasal bone. A record review of Resident #25's "After Visit Summary" dated 08/10/2026 revealed the resident was evaluated for a fall and facial injury and diagnosed with an open fracture of the nasal bone. On 08/11/2026 at 11:45 AM, during an observation and interview, Resident #25 was observed getting out of bed. A soft protective helmet was observed on the television stand. Resident #25 stated he did not wear the helmet. A small scab was observed on the bridge of the resident's nose and left eyebrow. On 08/12/2026 at 12:20 PM, during an observation, Resident #25 was seated in his wheelchair and was not wearing the physician-ordered protective helmet. On 08/12/2026 at 12:30 PM, during an interview, Certified Nursing Aide (CNA) #2 stated Resident #25 refused to wear the helmet and had a known behavior of placing himself on the floor. CNA #2 stated that when the resident was first admitted to the facility, he banged his head on the floor when he did not get his way. CNA #2 stated the resident no longer banged his head on the floor but continued to place himself on the floor as a behavior. On 08/12/2026 at 1:45 PM, during an interview, Licensed Practical Nurse (LPN) #2 stated she was working when Resident #25 was found on the floor on 08/08/2026. LPN #2 stated the resident had a laceration to the left eyebrow and bridge of the nose and redness to the left knee. LPN #2 confirmed Resident #25 was not wearing his protective helmet at the time of the incident and stated the resident "never" wore the helmet because he refused it. LPN #2 stated the helmet had originally been implemented because of the resident's behavior of			M0640			

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M0640	Continued from page 2 hitting his head on the floor or wall. On 08/12/2026 at 2:00 PM, during an observation, Resident #25 was observed in his wheelchair approaching the nurses' station and was not wearing the physician-ordered protective helmet. On 08/12/2026 at 2:30 PM, during an interview and review of Resident #25's care plan, the Director of Nursing (DON) stated she had not observed Resident #25 wear the helmet because he refused to wear it. The DON confirmed the resident's care plan addressed placing himself on the floor and banging his head on the floor. The DON stated the care-plan intervention directing staff to offer a PRN medication if the resident refused the helmet and continued self-injurious behavior did not identify a specific medication. The DON stated the resident's care plan should contain specific care approaches, including medications and other interventions. On 08/12/2026 at 3:10 PM, during an interview and review of Resident #25's care plan, the Administrator stated the resident had a history of banging his head on the floor and a helmet had been ordered to prevent injury. The Administrator confirmed the care-plan intervention regarding use of a PRN medication was not specific and stated he expected the resident's care plan to be resident-centered and interventions to be specific. On 08/13/2026 at 1:30 PM, during an observation, Resident #25 was observed in his wheelchair near the nurses' station wearing a ball cap and not wearing the physician-ordered protective helmet. On 08/13/2026 at 2:20 PM, during an interview, Registered Nurse (RN) #3 stated Resident #25 "never" wore his protective helmet because he always refused it. RN #3 stated that when the resident refused the helmet, staff redirected and educated him. On 08/13/2026 at 2:30 PM, during an interview, CNA #3 stated she found Resident #25 lying on the hallway floor on 08/08/2026 with his hands and arms under his forehead, his broken glasses beside him, and his wheelchair behind him. CNA #3 stated the resident had not been wearing his helmet because he refused to wear it and "never" wore it. On 08/13/2026 at 3:00 PM, during a telephone interview, RN #4 stated she was the charge nurse when Resident #25 was found on the hallway floor on 08/08/2026. RN #4 stated the resident had lacerations to the left eyebrow and bridge of the			M0640			

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M0640	Continued from page 3 nose and redness or a superficial abrasion to the left knee. RN #4 stated Resident #25 had a history of placing himself on the floor multiple times per day for various reasons. A record review of Resident #25's "Face Sheet" revealed the facility admitted the resident on 08/07/2024 with diagnoses including Epilepsy and Bipolar Disorder. A record review of Resident #25's "Physician Order Report" for August 2026 revealed an active physician order for the resident to wear a helmet at all times when out of bed for safety due to hitting his head on floors and walls. A record review of Resident #25's Comprehensive Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/14/2026, revealed a Brief Interview for Mental Status (BIMS) summary score of 5, which indicated severe cognitive impairment. Section I identified diagnoses including Seizure Disorder or Epilepsy and Bipolar Disorder.			M0640			