MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25JA	A. BUILDING: _____ B. WING _____	C 12/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS STATE VETERANS HOME-JACKSON	4607 LINDBERGH DRIVE JACKSON, MS 39209

(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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI MS #23711) at the facility from 12/27/23 through 12/28/2023. CI MS #23711 was investigated for abuse. During the survey, the SA determined that although the complaint did not rise to the level of abuse, resident rights were violated. 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 requirement and cited M500. The facility had a census of 97 and was licensed for 150 beds.	M 000		
M 500	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	M 500		

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M 500	Continued From page 1	M 500		

nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical 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;

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M 500	Continued From page 2 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 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	M 500		

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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 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 Statute is not met as evidenced by:
Based on interviews and record reviews the facility failed to ensure that residents were treated

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M 500	Continued From page 4 with respect and dignity during meal service for one (1) of three (3) residents reviewed. Resident #1 Findings Include: On 12/27/23 at 2:35 PM, in an interview and observation of Resident #1, he stated staff do not always treat him with dignity and respect. He went on to say that when a Certified Nurse Aide (CNA) was feeding him the other day, she gave him a couple spoons of food and walked off. He stated she came back about several minutes later and gave him another spoonful of food and took the tray. He stated CNA#1 then stated, "I don't have time for this slow eating today." The resident revealed he is blind and cannot feed himself. He stated he told another staff member what had happened and that he was hungry. The resident admitted that he does eat slow, but it depends on what it is. Resident #1's eyes became watery, and tears rolled down his cheeks as he recalled the events surrounding what had happened. On 12/27/23 at 3:00 PM, in an interview with the Director of Nursing (DON), she stated she was not at the facility on the day of the alleged incident. She stated she got a call from Registered Nurse (RN) #1 on duty, telling her that a CNA came to her about Resident #1 not being fed. She stated the CNA that was assigned to assist Resident #1 with his meal, was an agency CNA and is suspended until the investigation is complete. She stated one of the facility's CNAs told the cart nurse that another CNA#1 was feeding Resident #1 and told him she didn't have time to "feed a slow eater today." She stated he repeated the same story to RN #1 when she spoke with him.	M 500		

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M 500	Continued From page 5 On 12/28/23 at 9:40 AM, in an interview with the Administrator, she confirmed that she felt Resident #1 was being truthful about the incident. She stated she had completed her investigation and had substantiated the resident's complaint. She stated CNA #1 would no longer be allowed to work at the facility. On 12/28/23 at 2:03 PM, in an interview with CNA #2, she stated she worked on 12/24/23 on the morning shift. She revealed that Resident #1 told her what happened during the evening meal the day before. CNA #2 stated the resident told her that CNA #1 did not feed him his food. She stated he told her that CNA #1 talked ugly to him about being a slow eater. On 12/28/23 at 2:21 PM, in an interview with Licensed Practical Nurse (LPN) #1, she stated she was the nurse working the cart on 12/23/23, when the alleged incident happened. She stated CNA #3 reported to her that Resident #1 had told him that CNA #1 was feeding him stated," I hate feeding slow 'expletive' people" and that he needs to eat faster. The resident stated she gave him 2 bites of food, walked away, came back about 10 minutes later an gave him another bite of food and took his tray and left the room. She stated she told RN#1, the evening supervisor, and she went to speak with Resident #1. LPN #1 revealed that reportedly the resident told RN #1 he was still hungry, so she went and got a tray of food and had staff feed him. On 12/28/23 at 2:28 PM, in a telephone interview with CNA #1, she stated she was the CNA that fed Resident #1 on 12/23/23. She stated the resident was complaining about having to eat pureed food. She reported that she explained to him that pureed food could help him eat it faster.	M 500		

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She denied cursing the resident. She stated she did not stop feeding him or take the tray away before the resident finished eating. She denied walking away after giving the resident two bites of food and returning to give him one more bite before removing the tray from the resident's room.

On 12/28/23 at 3:20 PM, during an interview, RN #1 confirmed that she was informed of the alleged incident as soon as she reported for duty. She proceeded to the resident and inquired as to what had transpired. She reported that the resident informed her that the CNA assigned to feed him during dinner stated, "She did not have time for slow 'expletive' feeders." CNA #1 then gave the Resident #1 two to three portions of food before leaving. She returned considerably later and offered him one final bite before removing his tray. According to the RN, she inquired whether the resident was still feeling hungry. When he confirmed that he was still hungry, she proceeded to get a pot pie for him from the kitchen.

On 12/28/23 at 3:47 PM, in a phone interview with CNA #3, he stated he was in dining room assisting the other residents with their dinner on 12/23/23. He stated when he returned to the hall to check on his residents, to see if they needed anything, Resident #1 was upset. He asked Resident #1 what was wrong, and the resident told him CNA #1 told him she did not have time to feed a slow feeder. He stated Resident #1 told him CNA #1 gave resident two bites of food, left came back later and told him to hurry up. He stated the resident said after another bite of food, CNA #1 took the tray and left the room.

Record review of the "Face Sheet," for Resident

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M 500	Continued From page 7 #1 revealed the facility admitted the resident on 9/1/21, with diagnoses that included Legal Blindness, Unspecified Dementia, unspecified severity, with behavioral disturbances, and Abnormal Weight Loss. Record review of the December 2023 "Physician Orders", for Resident #1, revealed an order written on 4/11/23, for "Mechanical Soft Diet - Pureed Meats". Record review of facility's investigation of the incident revealed that most of the staff's written and verbal reports of the incident were consistent. However, the investigation revealed that the facility had determined that the incident was "untrue", and that Resident #1 was being referred for evaluation by a behavioral health service. Record review of the Care plan revealed "Category Nutrition ... Intervention "Staff to set-up the resident's tray, with the resident to feed himself with verbal cues. Record review of the Care Plan revealed "Category Activities of Daily Living (ADL) ...Intervention ...Total assistance with meals ..." Record review of the Minimum Data Set (MDS), with Assessment Reference Date (ARD) 11/6/23, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Section GG revealed the resident is dependent on staff for eating.	M 500		