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
	04KO	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS STATE VETERANS HOME-KOSCIUS	310 AUTUMN RIDGE DRIVE KOSCIUSKO, MS 39090

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M 000	Initial Comments The State Agency (SA) conducted a complaint investigation (CI) MS# 25127, CI MS# 25565, CI MS# 26033, CI MS# 26148, and CI MS# 26456 at the facility on 9/16/24 through 9/17/24 During the survey, the SA determined that the facility was not in compliance with the requirements of the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The SA identified non-compliance and cited M 500 for CI MS# 26033 and CI MS# 26148 related to Resident Rights and cited M 640 for CI MS# 26456 related to Accidents. There were no deficiencies cited for CI MS# 25127, or CI MS# 25565 The census at the time of the survey was 129 with a bed capacity of 150 beds.	M 000	A) What correction action(s) will be accomplished for those residents found to be affected by the deficient practice citation M500-45 17 2? • On July 30, 2024, Resident #2 was affected by the deficient practice. Resident #2 was evaluated by Registered Nurse (RN) supervisor on duty and transferred to local Emergency Room for further evaluation Resident #2 returned to facility on 07/30/24 with laceration repair to face CT of face and head showed no acute abnormalities B) How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken • All residents have a potential to be affected by the deficient practice C) What measures will be put into place, or what systemic changes you will put into place or make to ensure that the deficient practice does not recur • On 7/31/24, Resident #3 was referred and transferred to behavioral geriatric psychiatric facility for additional evaluation Resident'#3's care plan was revised related to aggressive behaviors on 8/1/24 Resident #2 was relocated from unit to avoid future interaction between Resident #2 and Resident #3 on 8/9/24 • On 8/14/24, Social services director notified Resident #3's responsible party regarding recommendation of discharge if harmful physical altercation occurs between him and any other residents. • Starting on 09/26/24, B-wing/locked unit will receive additional nursing staff to provide increased surveillance and to monitor residents that wander starting on 9-26-24 Staff will provide re-direction for residents that exhibit aggressive behaviors and/or by providing meaningful activities/interactions to re-orient aggressive behaviors Residents with observed physically aggressive documented behavior will be monitored every 30mins * 72hrs • Starting on 10/3/24, Residents with physically aggressive behavior to self and/or others will receive documented pharmacy drug review post-behavior along with collaboration from medical director and/or in-house psychiatric nurse practitioner as needed to ensure resident is receiving optimal dose of medications to reduce aggression • Staff training/in-services started on Sept 24th, 2024, on recognizing aggression in residents in In-Service/Training Nurse	10/29/24
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;	M 500		

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M 500	Continued From page 1 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 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	M 500	• A Quality Assurance Meeting will be held by 10/29/24 by the Inter-Disciplinary team to include Nursing Managers, Administration, Social Services, Activities Director, and MDS Nurses to review plan of correction Any areas of deficit will be addressed QA committee will continue to monitor for an additional quarter to ensure compliance/recommendations are still being followed D) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i e what quality assurance program will be put into place • Starting on 10/3/24, Registered Nurse on duty will monitor B-wing/locked unit to ensure adequate nursing staffing is present and nursing staff is monitoring hallways and common areas for wanderers 2x daily on (day and night) shift along with correcting any deficiencies observed along with documentation for quality assurance improvement • Starting on 10/3/24, Pharmacist will conduct a weekly review of residents with documented physically aggressive/inappropriate behaviors and ensure the drug review regimen is completed and any recommendations for medication changes is completed in a timely manner after each documented behavior of physical aggressiveness towards other residents and/or staff • Starting on 07/31/24, Social services Dept. will continue to update residential care plans for residents that exhibit physical aggression and/or inappropriate behaviors in a timely manner (<72hrs post-behavior) • Starting 10/3/24, Social services will review residents with recurring aggressive/inappropriate behaviors on a weekly basis to ensure they are receiving person center-related social activities and/or interactions to minimize physical aggression by collaborating with Activities Department and providing meaningful activities as needed • A Quality Assurance Meeting will be held by 10/29/24 by the Inter-Disciplinary team to include Nursing Managers, Administration, Social Services, Activities Director, and MDS Nurses to review plan of correction Any areas of deficit will be addressed QA committee will continue to monitor for an additional quarter to ensure compliance/recommendations are still being followed	

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M 500	Continued From page 2 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 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	M 500		

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M 500	Continued From page 3 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 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	M 500		

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M 500	Continued From page 4 This Statute is not met as evidenced by: Level III Based on staff interviews, record reviews, and facility policy reviews, it was determined that the facility failed to protect the rights of one (1) of 112 residents to be free from abuse or neglect when Resident #3 entered Resident #2's room and physically assaulted Resident #2. Findings include· Record review of facility policy titled, "Abuse Policy and Procedure", review date 5/13/22 revealed, "General The resident has a right to be free from verbal, sexual, physical or mental abuse, corporal punishment and voluntary seclusion The facility will strive to maintain an environment that is free from threat of and/or occurrence of harassment, abuse . " A review of the facility's investigation revealed that on 7/30/24, at 5 55 PM, Certified Nursing Assistant #1 (CNA) entered Resident #2's room and found Resident #3 standing over Resident #2. Resident #2 was noted to have blood on his face and reported that Resident #3 had thrown his walker at him and hit him several times in the face with his fist A skin tear was observed near Resident #2's left eye, along with a dime-sized hematoma beside the same eye. The residents were immediately separated, first aid was administered to Resident #2, and he was sent to a local emergency department (ED) for further evaluation ED Provider Notes revealed laceration and bruising to the face. Laceration above left eyebrow closed with Dermabond glue A referral was made to the behavioral health unit, and Resident #3 was transferred there on 7/31/24, for evaluation and treatment	M 500		

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M 500	Continued From page 5 During an interview on 9/17/24 at 8:50 AM, CNA #1 explained that on the day of the incident, he had just left another resident's room when he heard a commotion. Upon entering Resident #2's room, he saw Resident #3 standing over Resident #2, with blood on Resident #3's hands and Resident #2's face He separated the residents, called for help, and a nurse arrived CNA #1 stated that Resident #3 admitted to hitting Resident #2 He noted that Resident #3 has a history of wandering and confirmed that Resident #3 has a history of aggression, particularly when he does not get his way, and has previously threatened staff CNA #1 confirmed that one-on-one monitoring (1 1) was not provided for Resident #3 prior to the incident. In a telephone interview with Registered Nurse #1 (RN) on 9/17/24 at 9 06 AM, she recalled that when she began her shift, she went to the B wing to make rounds. Staff urgently called her to Resident #2's room, where she saw Resident #3 with his fist raised and noted swelling on Resident #2's face. RN #1 stated that Resident #3 admitted to hitting Resident #2 and throwing his walker at him. Resident #2 reported that the altercation was over Resident #3 wanting his snacks, and that Resident #3 had hit him five (5) to six (6) times before staff arrived. RN #1 confirmed that Resident #3 has a history of aggression and often wanders into other residents' rooms. She also noted that CNAs are typically stationed in the halls between rounds to monitor the residents, but there was no one-on-one monitoring of Resident #3 to prevent aggression toward other residents prior to this incident. In an interview on 9/17/24 at 9 41 AM, the Administrator (ADM) and Director of Nursing	M 500		

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M 500	Continued From page 6 (DON) verified that Resident #3 frequently wanders throughout the facility and into other residents' rooms They also confirmed his history of aggressive behavior. The ADM and DON acknowledged that no special interventions or one-on-one monitoring were in place during the evening and night shifts The DON agreed that increased monitoring could reduce the risk of aggression toward other residents but confirmed that such measures had not been implemented Record review of Face Sheet revealed the facility admitted Resident #2 on 4/8/24 with a diagnosis of Dementia. Record review of Resident #2 ' s Quarterly Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 7/12/2024 revealed a Brief Interview for Mental Status (BIMS) score of 99 indicating resident was unable to complete assessment Record review of Face Sheet revealed the facility admitted Resident #3 on 3/4/24 with diagnoses that included Psychosis, Hallucinations, Delusional Disorders and Dementia Record review of Resident #3 ' s Quarterly Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 9/4/2024 a Brief Interview for Mental Status (BIMS) score of 99 indicating resident was unable to complete assessment	M 500		
M 640	45 21 8 Accidents Accidents The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate	M 640	A) **What correction action(s) will be accomplished for those residents found to be affected by the deficient practice citation: M500-45.17.2?** • Resident #1 was sent to Emergency Room on 9/11/24 after sustaining a fall in vehicle during transit. Resident was transferred from VA Medical Center to UMMC for further evaluation. He was diagnosed with a Lumbar (L2 & L3) transverse process fracture	

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M 640	Continued From page 7 supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies This Statute is not met as evidenced by: Level III Based on resident and staff interviews, record reviews, and facility policy reviews, the facility failed to ensure a resident was free from accidents or hazards when a resident was not properly secured in the facility van during transportation to an outside appointment, resulting in a fracture. This incident involved one (1) of three (3) residents reviewed for accidents. Resident #1 Findings include Record review of a facility policy, titled, "Accident Prevention" approved 8/4/2023 revealed "The [Proper Name of Facility] makes every effort to provide a safe environment for its residents " Record review of "Sure-Lock Safe and Secure" manufacturing instructions revealed " Safety information . All Sure-Lock Wheelchair Tie Down Systems shall be used in conjunction with Sure-Lock Occupant Restraint Systems and Track, Floor Plates or Anchoring Hardware " A review of the facility's investigation dated 9/12/24, revealed that on 9/11/24 at approximately 9 00 AM, while being transported in the facility van to an appointment, Resident #1 yelled out that he was falling. When staff turned around, they observed that Resident #1 was lying on his back in his wheelchair on the floor of the van The Van Driver had failed to properly secure the resident's wheelchair, causing it to tip	M 640	**B) How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken.** • All residents have a potential to be affected by the deficient practice. Staff involved were in-serviced on proper anchoring mechanism and educated on resident safety Assigned driver educated and was required to pass safety checklist on 9/6/24 C) **What measures will be put into place, or what systemic changes you will put into place or make to ensure that the deficient practice does not recur** • Starting on 9/13/24, all transport personnel must complete a pre-trip checklist that includes verification of seat belt in place, front anchors, back anchors, and brakes before departure Signature required for both the driver and transport aide/staff on each resident being transported • Starting on 9/13/24, All staff approved to drive transport vehicles must demonstrate how to safely anchor, latch, and lock all seats in place Staff must pass several skills before approval for safe driving • In-Service started on Sept. 24th, 2024, by In-Service Nurse, Administrator, and Maintenance Supervisor for all MSVA staff to include images on anchoring wheelchairs and directions on how to safely anchor residents in a transport vehicle. • A Quality Assurance Meeting will be held by 10/29/24 by the Inter-Disciplinary team to include Nursing Managers, Administration, Social Services, Activities Director, and MDS Nurses to review plan of correction Any areas of deficit will be addressed QA committee will continue to monitor for an additional quarter to ensure compliance/recommendations are still being followed D) **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place** • Starting on 09/13/24, Facility Maintenance Director/Facility Maintenance Supervisor will monitor transport pre-trip checklist to ensure the form is completed on a weekly basis for the next 4wks then monthly for an additional 2 months • Any observed deficient practice will be addressed immediately Maintenance Director/Maintenance Supervisor will conduct a formal training for all new drivers before being approved to transport residents A Quality Assurance Meeting will be held by 10/29/24 by the Inter-Disciplinary team to include Nursing, Administration, and Maintenance Dept. Managers to review plan of correction Any areas of deficit will be addressed QA committee will continue to monitor for an additional quarter to ensure compliance/recommendations are still being followed	10/29/24

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M 640	Continued From page 8 backward when he made a left-hand turn. Resident #1 was transferred to the hospital, where he was diagnosed with acute fractures of the second and third lumbar spine A review of the hospital's "Neurosurgical History and Physical" dated 9/12/24 stated· "[Resident's name] presents after a fall when the patient was reportedly not secured appropriately and fell out of his wheelchair acute right second lumbar transverse process fracture (R L2 TP fx) No acute neurosurgical interventions recommended, pain control, no bracing, no need for spinal precautions " In an interview on 9/16/24 at 1·00 PM, Resident #1 stated that on 9/11/24, while in the facility van, the Van Driver made a left turn, causing his wheelchair to tip backward, and he fell onto his back He mentioned that if the Van Driver had secured his wheelchair with the front anchor straps, the incident would not have occurred. Although he was not initially in pain, he began to feel discomfort later and was subsequently sent to the emergency room During an interview with the Van Driver on 9/16/24 at 1:40 PM, he confirmed that on 9/11/24, while securing Resident #1 in the van, an office employee approached him and asked him to take some checks to the bank Distracted by the conversation, he failed to complete securing Resident #1's wheelchair with the front anchor straps He acknowledged that he should have ensured the resident was properly secured to prevent injury Certified Nursing Assistant #2 (CNA), interviewed on 9/16/24 at 1.47 PM, confirmed that she was present in the van during Resident #1's transport	M 640		

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M 640	Continued From page 9 on 9/11/24. She recalled that when the Van Driver made a left-hand turn, she heard Resident #1 say, "I am falling " When she turned around, she saw that the resident's wheelchair had tipped backward, and Resident #1 was lying on his back in the wheelchair. She stated that securing the residents for transport was the Van Driver's responsibility but acknowledged that she usually checks to ensure residents are properly secured before departure, although she did not check that day. CNA #3, interviewed on 9/16/24 at 1 53 PM, also recounted that while in the facility van on 9/11/24, she heard Resident #1 yell that he was falling When she looked, she saw that his wheelchair had tipped backward, and he was lying on his back CNA #3 confirmed that securing residents for transport was the Van Driver's responsibility and admitted that she does not typically verify if residents are properly secured, but she acknowledged that she should In an interview with the Administrator (ADM) on 9/16/24 at 2 00 PM, she confirmed that her investigation revealed that Resident #1 was not properly secured in the van by the Van Driver prior to transport The Van Driver failed to secure the front anchor straps to the resident's wheelchair, which led to the incident ADM stated that there are typically at least two (2) staff members on the van for transport, and both staff members are responsible for ensuring that residents are properly secured before leaving Record review of the "Face Sheet" revealed the facility admitted Resident #1 on 12/3/20 with a diagnosis of Congestive Heart Failure Record review of a quarterly Minimum Data Set	M 640		

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M 640	Continued From page 10 Assessment (MDS) with an Assessment Reference Date (ARD) of 9/17/24, indicated a Brief Interview for Mental Status (BIMS) score of 13, indicating that the resident is cognitively intact	M 640		