STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16CO	A. BUILDING: _____ B. WING _____	C 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS STATE VETERANS HOME-COLLINS	3261 HIGHWAY 49 SOUTH COLLINS, MS 39428

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M 000	Initial Comments The State Agency (SA) conducted Complaint Investigations (CIs), at the facility from 8/27/25 through 8/28/25. CI MS #29335 was investigated for an allegation of neglect regarding a resident with dementia allegedly not provided adequate supervision, was frequently hospitalized, became severely dehydrated, developed wounds, and was not provided timely assistance with toileting, feeding, or therapy. CI MS #29663 was a Facility Reported Incident (FRI) investigated for an allegation of abuse when one resident was observed physically striking another resident in the dining area and staff intervened. CI MS #29698 was a FRI investigated for an allegation of verbal abuse when one Certified Nurse Aide (CNA) accused another CNA of being verbally abusive toward a resident.CI MS #29042 was investigated for Pressure Ulcers and not changing an indwelling catheter. There were no citations related to these CIs. 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 related to CI MS #29697 which was a FRI and was investigated for an allegation of neglect when a resident was reportedly left in a chair for eight hours without being changed, and M500 was cited.	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	M 500		

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M 500	Continued From page 1	M 500		

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 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

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M 500	Continued From page 2 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; 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	M 500		

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M 500	Continued From page 3 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 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	M 500		

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M 500	Continued From page 4	M 500		

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:
Level II

Based on observation, staff interview, record review and facility policy review the facility failed to ensure Resident #1's right to dignity by leaving her seated in a Geri-chair for over eight (8) hours without assistance for toileting, changing, or repositioning, despite being dependent on staff for activities of daily living (ADLs) for one (1) of four (4) residents reviewed for Resident Rights. Resident #1

Findings include:

A review of the facility's, "Resident Rights Policy", last reviewed March 11, 2022, revealed, "The Resident has a right to a dignified existence, self-determination and communication with an access to persons and services inside and outside the facility..."

A record review of the "Facility Investigation" revealed that on 8/12/25 from 6:34 AM until 7:45 PM, according to facility video surveillance, Resident #1 was up in her geriatric chair (geri-chair) and re-positioned/straightened four (4) times throughout the course of the day,

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M 500	Continued From page 5 however she was not changed during that time. On 8/27/25 at 11:45 AM, during an interview with the Administrator, he confirmed, that on 8/12/25 according to the surveillance video, Resident #1 was left in her chair for approximately 8 hours on 8/12/25, during Certified Nursing Assistant (CNA) #1's shift. The facility continues to perform there investigation. CNA#1 has been placed on Administrative leave, pending their investigation, and they have performed in-services to all staff on Abuse and Neglect. He stated that CNA #1 should have assisted Resident #1 to her room every two (2) hours, if not more frequently, for repositioning and changing the resident's brief. He confirmed CNA #1 failed the resident by not treating her with dignity every 2 hours for position changes and keeping the resident clean and dry. On 8/27/25 at 12:15 PM, an interview with the Director of Nurses (DON) revealed on 8/12/25, CNA #1 did leave Resident #1 up in a geri-chair during her 8-hour shift. The DON explained that Resident #1 is considered total care and is dependent upon staff for ADLs and requires staff to change her brief. She stated it was not the facility's practice to leave residents up without checking there brief, repositioning, or changing them every 2 hours, if not more frequently. The DON confirmed that the resident did not develop a pressure sore following the episode or urinary tract infection. On 8/27/25 at 2:00 PM, during a phone interview with CNA #1, she confirmed that she did leave Resident #1 up in the geri-chair for over 8 hours throughout her shift on 8/12/25. She stated that she did reposition the resident and did check the resident throughout the day to determine if she was wet or soiled, which she was not.	M 500		

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M 500	Continued From page 6 On 8/27/25 at 3:00 PM, during an observation of the surveillance video from 8/12/25, Resident #1 was up in her geri-chair from 6:34 AM until 7:45 PM. CNA #1 was observed to repositioned the resident in the chair four (4) times throughout her 8-hour shift. A record review of the "Resident Face Sheet" revealed the facility admitted Resident #1 on 3/6/24 with diagnoses including Dementia. A record review of Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/6/25 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) Summary of 2, which indicated she was severely cognitively impaired.	M 500		