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M 000	Initial Comments The State Agency (SA) conducted a complaint survey, MS #16997 and MS #16703, from 08/13/2020 through 08/17/2020. The SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm. The SA substantiated MS #16997 related to Quality of Care with deficiencies cited at M500, M610, and M645. The SA substantiated MS #16703 related to falls with no deficiencies cited. The facility had a census of 131 at the time of the survey, and held a license 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 nurse practitioner/physician assistant of his	M 500		

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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 with persons of his choice, may join with other	M 500		

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M 500	Continued From page 3 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: Level II Based on Responsible Party interview, staff	M 500		

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M 500	Continued From page 4 interview, record review and facility policy review, the facility failed to notify the Responsible Party of a significant weight loss for one (1) or four (4) residents reviewed for weight loss, Resident #1. Findings include: Review of the facility's "Resident's Rights" policy, revised 09/1997, revealed, the resident assured of adequate and appropriate medical care, is fully informed, by a physician, of his medical condition unless medically contraindicated (as documented, by a physician, in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to refuse to participate in experimental research, and to refuse medication and treatment after being fully informed of and understanding the consequences of such actions. Review of the facility's "Change in a Resident's Condition or Status" policy, dated June 26, 2012, MSNH 250-35, revealed, 2) GENERAL: It is important to keep the resident, the resident's physician, and the resident's representative informed of changes in his/her condition or status. 3) PURPOSE: It is the policy of the Mississippi State Veterans Home to promptly notify the resident, his/her attending physician and resident's representative of changes in the resident's condition or status. 4) PROCEDURE: The Nurse Supervisor will notify the resident's attending physician when there is a significant change in the resident's physical, mental or psychosocial status. Unless otherwise instructed by the resident, the nurse supervisor will notify the resident's representative when there is a significant change in the resident's physical, mental or psychosocial status.	M 500		

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M 500	Continued From page 5 During an interview, on 08/13/2020 at 9:00 AM, with Resident #1's Responsible Party (RP), she stated that on 08/07/2020, her father, Resident #1, was transported to the hospital after her sister Face Timed him and noticed a decline in his cognitive status and appearance. The RP stated her sister asked for a nurse to assess him and Resident #1 was sent to the hospital. The RP stated her sister was able to see him at the hospital and was appalled at his appearance. She stated Resident #1 appeared emaciated. The RP stated the facility had not notified them of his weight loss. The RP stated that they got regular wound status notifications. The RP stated Resident #1 had Macular Degeneration and had to be fed all meals, that he would sometimes become aggressive during feeding, but that he drank from a straw well. The RP stated she and her sister had been going to the facility four to five times a week and feeding him before March 14th. The RP stated she thought Resident #1's weight was 108 pounds in July 2020. She stated that she had spoken with Licensed Practical Nurse #1 (LPN) who revealed she had not worked on his hall in two (2) weeks, and she had noticed a decline in Resident #1's status since she was last there. The RP stated the Administrator admitted that the facility had not notified the family of his weight loss. Record review of the Weight Change Comparison for Resident #1, revealed, he had a -18.69 percent (%) weight loss in 30 days from 07/07/2020 - 08/06/2020. On 08/14/2020 at 12:32 PM, during an interview, with the Director of Nursing (DON), she stated weekly weight meetings are held in which they go over everything, then they would notify the Medical Doctor (MD) and RP and write a nurses	M 500		

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note. The DON stated she did not know why the RP was not notified of Resident #1's weight loss. She stated the Unit Manager or Nurse should notify the RP of any changes in the residents' status. The DON stated she had reviewed Nurses' Notes and did not see any family notification in the Nurses' Notes within the last 90 days. The DON stated the only notification of a weight change she could find in the Nurses' Notes was on 02/14/2020 when she called the RP due to Resident #1's edema and Lasix discontinuation. She stated the nurses are instructed to document any changes with residents' status and notify the Doctor and Responsible Party.

During an interview, on 08/14/2020 at 1:10 PM, with the Administrator, she revealed, the only other weight notification she could find for Resident #1, was a Care Plan Conference on 05/21/2020 in which the resident's diet was discussed and the RP was documented as having attended by phone. The Administrator stated it was the policy of the facility to notify the RP of any change in a resident's status.

On 08/14/2020 at 1:14 PM, during an interview, the Registered Dietitian (RD) stated that the nurses call the families with any changes. The RD stated that in July she had documented a non-significant weight change because Resident #1's weight went up and down.

During an interview, on 08/14/2020 at 1:55 PM, with Registered Nurse #1 (RN)/Unit C Manager, she stated that she did not recall ever calling Resident #1's RP regarding weight loss.

Interview with the Physician Assistant (PA), on 08/17/2020 at 11:37 AM, he stated Resident #1's

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M 500	Continued From page 7 weights vary by five (5) -10 pounds sometimes, and that he had not been doing well. The PA stated Resident #1 would not take the Eldertonic, that it tasted pretty bad, and that he was planning to review Resident #1 with the Pharmacist. He stated he was considering adding Cyproheptadine or Marinol as an appetite stimulant, but that it sometimes made dementia worsen. Review of the Progress Note, dated 07/11/2020, written by the PA-C, revealed, "(Resident #1) was seen today. He has noted decreasing appetite and weight loss along with other residents during this COVID-19 pandemic. Patient's chart was reviewed today along with his labs. Plan: Follow up (F/U) consult with pharmacy for either Elder tonic, Cyproheptadine, or Marinol for weight loss. It's seen that he has lost weight along with dementia not helping due to gradually declining of illness."	M 500		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II	M 610		

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M 610	Continued From page 8 Based on observation, staff interview, record review, and facility policy review, the facility failed to provide fingernail care, as evidenced by, long, jagged fingernails with brown matter beneath the nails of Resident #2, for one (1) of four (4) residents observed for Activities of Daily Living (ADLs). Findings include: Record review of the facility's "Nail and Foot Care Policy", dated February 4, 2013, revealed, "2. GENERAL: The Mississippi State Veterans Home will provide nail and foot care to the residents to ensure the nail beds are clean, nails are trimmed, and to prevent infections." On 8/13/2020 at 12:30 PM, during an observation of Resident #2 and interview with Licensed Practical Nurse (LPN) #1, Resident #2's fingernails were long and jagged with a brown substance beneath all nails. LPN #1 confirmed Resident #2's fingernails were long and dirty and that she didn't know what the brown substance was beneath them. LPN #1 stated Resident #2 was not very compliant and would say "leave me alone, quit, quit" and that he probably refused nail care. LPN #1 stated the residents' hands should be cleaned every day. LPN #1 measured the length of Resident #2's nails using a paper measuring device, and the nails were noted to be 0.5 cm from the tip of the finger. During an interview, with the Administrator on 08/13/2020 at 1:45 PM, she stated staff should keep residents fingernails trimmed and clean. The Administrator stated, "They should go in and soak them (nails), especially with his (Resident #2) bath. He scratches and spits at staff. It's a	M 610		

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M 610	Continued From page 9 battle with him allowing care." Record review of Resident #2's Treatment Administration Record (TAR) for June, July and August of 2020, revealed, an order dated 02/14/2020, for "Diabetic nail care every month by Registered Nurse (RN) or Podiatrist." Diabetic nail care was initialed as completed on June 13, 2020. Diabetic nail care was not documented as completed on the July or August 2020 TAR. Record review of the Care Plan Description, revealed, Resident #2 "is at risk for self care deficit with Activities of Daily Living (ADL) related to diagnosis of Dementia." An intervention indicated to "Trim nails and provide nail care as scheduled and as needed (PRN)." Record review of the Face Sheet for Resident #2, revealed, he was admitted to the facility on 03/15/2016, with a diagnosis of Dementia in Other Diseases Classified Elsewhere with Behavioral Disturbances. A record review of the Significant Change Minimum Data Set (MDS) dated 06/23/2020, revealed in Section C (Cognitive Patterns), revealed, Resident #2 scored 3 on the Brief Interview for Mental Status, which indicated severely impaired cognitive skills for daily decision making.	M 610		
M 645	45.21.9 Nutrition Nutrition. Residents shall maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless residents ' clinical condition indicates that this is unavoidable. All residents shall receive diets as	M 645		

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orders by their physician or nurse practitioner/physician assistant. Residents identified with significant nutritional problems shall receive appropriate medical nutrition therapy based on current professional standards.

This Statute is not met as evidenced by:
Level II

Based on family interview, staff interview, record review, and facility policy review, the facility failed to follow the physician orders for daily weights, for a resident with known weight loss, for one (1) of four (4) residents reviewed for weight loss, Resident #1.

Findings include:

Review of the facility's "Weight Loss Prevention Program" policy, dated December 18, 2012, MSNH 200-118, revealed, GENERAL: The Mississippi State Veterans Home must ensure that a resident maintains acceptable parameters of nutritional status in order to maintain a healthy weight and prevent weight loss. PROCEDURE: 3. Residents that are nutritionally at risk will be placed on weekly weights when indicated.

Review of the facility's "Weight Monitoring Program" policy, dated December 18, 2012, MSNH 100-119, revealed, PURPOSE: It is the policy of this facility that each resident's weight be monitored monthly or as indicated by the resident's condition or physician's order.

During an interview, with the Responsible Party (RP) for Resident #1, on 08/13/2020 at 9:00 AM, she stated Resident #1 was transferred to the hospital after her sister noticed a decline in his cognitive status and appearance via Face Time.

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The RP stated her sister asked for a nurse to assess Resident #1, and he was sent to the hospital. The RP stated her sister was able to see Resident #1 at the hospital and was appalled at his emaciated appearance. The RP stated the facility had not notified them of his weight loss. She also stated Resident #1 had Macular Degeneration and had to be fed all meals, that he would sometimes become aggressive during feeding, but that he drank well from a straw. The RP stated she and her sister had been going to the facility four to five times a week and feeding Resident #1 before March 14th. The RP stated she thought Resident #1's weight was 108 pounds in July 2020. She stated she had spoken with Licensed Practical Nurse #1, who revealed she had not worked on Resident #1's hall in two (2) weeks and that she had noticed a decline in his status since she was last there. The RP stated the Administrator admitted the facility had not notified the family of Resident #1's weight loss. The RP stated her father (Resident #1) was admitted to the facility in November of 2019 with Lewy Body Dementia.

Record review of the 07/16/2020 Weight Change Comparison, from the 07/17/2020 Weekly Weight Meeting, revealed, Resident #1 was discussed for a re-weigh at the meeting due to a 6.80 pound decrease noted from 07/07 - 07/10/2020.

Record review of the Physician Order List, dated 08/13/2020, revealed, an order dated 02/07/2020, for Daily Weights.

Record review of the Weight Change Comparison for Resident #1 from 02/04/2020 - 08/06/2020, revealed, daily weights were documented 02/06/2020 - 02/10/2020. Further review of the record, revealed, Resident #1 had no weights

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recorded between 07/10/2020 and 08/06/2020. Resident #1's weight on 07/10/2020 was 115.6# and on 08/06/2020, he weighed 94.0# which equaled a -13.60 % and -14.80 # weight loss.

During an interview, on 08/14/2020 at 1:14 PM, with Registered Dietitian (RD) #1, she stated that on 07/17/2020, it was discussed in the Weekly Weight Meeting that there was a discrepancy with Resident #1's weights from 07/07/2020 and 07/10/2020 of 6.8 pounds in 3 days, and a re-weigh was requested. RD #1 stated she emailed the DON and Administrator on 07/29/2020 and 07/30/2020 stating that she had not received several re-weight requests from the previous weight meeting. She stated she did not get another weight on Resident #1 until 08/06/2020 and that weight was 94 pounds. She stated his diet provided 4,120 calories and 150 grams (g) protein which included meal trays and supplements. Resident #1's documented oral (PO) intake from 07/12/2020 - 08/07/2020 was 50-100 percent (%) of meals, 50-100% of snacks, and the average intake was 2,030 - 3,090 calories and 113 g protein. RD #1 stated that at 50% intake, Resident #1 would be getting more than 2,000 calories and 75 grams protein. She revealed Resident #1 needed just under 2,000 calories to meet the high end of his increased needs for wound healing and to get him up to his Ideal Body Weight (IBW). RD #1 stated that in July she had documented a non-significant weight change because his weight went up and down. She stated he was normally weighed weekly. The RD stated his Ideal Body Weight (IBW) was 124 pounds (#) and his height was 5 feet 3 inches.

Record review of emails sent by RD #1 to the Director of Nursing (DON) and the Administrator,

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on 07/29/2020 and 07/30/2020, revealed, she sent reminders for a re-weigh on Resident #1.

During an interview, on 08/14/2020 at 1:55 PM, with Registered Nurse #1 (RN)/Unit C Manager, she stated that she started work in April, and that the DON was handling all of the weights with the Restorative Certified Nursing Assistants (CNA), both of whom are no longer employed at the facility. RN #1 stated she had actually taken over getting the weights in August, and remembered a lot of discrepancies at first. She stated an in-service was held on correctly obtaining weight, such as using the right scale for the resident and zeroing out the scale. RN #1 stated she did not recall a re-weigh being requested on Resident #1 in July, and did not recall ever calling his Responsible Party (RP).

A record review of the facility's document "In-service on Weight Days and Completing Weights on Days Assigned", dated 08/06/2020, revealed: Unit are now responsible for obtaining weights. Unit Managers are to assign and make sure weights are completed prior to the end of the day. Tuesday: C-Wing, When weighing resident please use the same weight device previously used to get the weight. We do not want any discrepancies. This is to ensure that we have the most accurate weight as possible to ensure that we can adjust the residents plan of care correctly. RN #1 signed as having attended this in-service.

An interview with the Administrator, on 08/14/2020 at 2:30 PM, she stated the Restorative Aides did the weights on the C Unit, and the Unit Manager was recently assigned the task of obtaining weights. The Administrator stated she did recall an issue during July with discrepancies, and the scales with some weights

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	25JA	A. BUILDING: _____ B. WING _____	C 08/17/2020

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

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as much as 30 pounds (#) off. She stated that she had Maintenance to check the scales and they were now able to get a more accurate weight. The Administrator stated an in-service was held on weights on 08/06/2020. She stated some weights were as much as 30 pounds off. She stated Resident #1 was supposed to be weighed on a wheelchair scale. The Administrator stated Resident #1 would be rolled onto the scale, and then the weight of the wheelchair would be deducted. She stated Resident #1 was a weekly weight. The Administrator stated the two (2) Restorative Aides, who are no longer employed with the facility, had obtained some weights the week of 07/29/2020 but that staff were unable to find the weights. She stated the RD conducts a weight meeting weekly, usually on Friday, attended by the Minimum Data Set Nurse (MDS), Administrator, all Unit Managers, the Weight and Wound Nurses, Speech Therapist (ST), DON, Assistant Director of Nursing (ADON), Social Worker (SW) and Pharmacist. The Administrator stated she was unable to locate any weights on Resident #1 between 07/10/2020 - 08/06/2020. She revealed the DON said she remembered the Restorative CNAs getting some weights, but she couldn't find the weights.

During an interview, with the Physician Assistant (PA), on 08/17/2020 at 11:37 AM, he stated Resident #1 should have been weighed weekly. He stated an order for daily weights on Resident #1 would have been an error. The PA stated it would have been important for Resident #1 to be weighed weekly to keep track of his weight and that he was unaware that Resident #1 had not been weighed between 07/10/2020 and 08/06/2020. The PA stated, "Wow. I will make sure to touch base with (Medical Doctor) to make

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sure we don't have that problem with other residents." The PA stated with COVID-19, weight losses and worsening dementia have been a problem with residents. He stated Resident #1's weights varied by 5-10 pounds sometimes and that he had not been doing well. The PA stated Resident #1 would not take the Eldertonic, that it tasted pretty bad, and he was planning to review Resident #1 with the Pharmacist. He stated that he was considering adding Cyproheptadine or Marinol as an appetite stimulant, but that it sometimes made dementia worsen.

A review of the Physician Assistant's (PA-C) Progress Note, dated 07/11/2020, revealed, "Resident name (Resident #1) was seen today. He has noted decreasing appetite and weight loss along with other residents during this Covid-19 pandemic. Patient's chart was reviewed today along with his labs. Physical Exam: Vital signs stable (VSS), Head, Eyes, Ears, Nose and Throat Exam (HEENT): Normocephalic, atraumatic (NC/AT), pupils equal round reactive to light and accommodation (PERRLA), Supple neck, Cardiovascular (CV): Regular rate and rhythm (RRR) , no murmurs, rubs or gallops (M/R/G), Lungs: clear bilateral breath sounds with soft non-distended abdomen. Neuro: demented at baseline, Skin: warm and moist and well perfuse. Lab: reviewed, Impression: 1) Chronic Kidney Disease (CKD), 2) Hypertension (HTN), 3) Heart Disease 4) Dementia 5) Amnesia 6) Thyroid Disease (dx) 8) Visual Hallucinations. Plan: Follow up (F/U) consult with pharmacy for either elder tonic, Cyproheptadine, or Marinol for weight loss. It's seen that he has lost weight along with Dementia not helping due to gradually declining of illness."

Record review of the Face Sheet for Resident #1,

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M 645	Continued From page 16 revealed, he was admitted by the facility 11/18/2019, with diagnoses to include, but not limited to, Dementia with Lewy Bodies, Chronic Kidney Disease, Stage 3 (moderate), Acute Pyelonephritis, Localized Edema, Personal History of Urinary Tract Infections and Rheumatoid Arthritis, Unspecified.	M 645		