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
	36OX	A. BUILDING: _____ B. WING _____	C 04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS STATE VETERANS HOME-OXFORD	120 VETERANS DRIVE OXFORD, MS 38655

(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), for MS# 30370 and CI MS# 30457 at the facility from 04/28/26 through 04/29/26. During the survey, the SA determined that the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. The facility failed to provide a safe environment and failed to protect a resident from a known hazard and was cited M640 for CI MS # 30457. However the facility had put corrective measures in place to correct the deficient practice prior to SA entrance. There were no deficiencies cited for CI MS # 30370. This failure resulted in Resident # 1, who ignited a cigarette while receiving oxygen therapy and is a cognitively impaired resident, to sustain burn injuries from the fire that required emergent medical treatment and transfer to a burn center on 4/18/26 at 9:35 PM. During the investigation, the SA identified a Level 4 citation which began on 4/18/26. The Level 4 citation existed at Rule 45.21.8 -M640. The facility's failure to provide supervision resulted in serious injury and harm for Resident #1 and was likely to cause serious injury, harm, impairment or death other residents residing in the facility. The SA notified the facility Administrator of the Level 4 citation on 04/28/26 at 1:50 PM. Based on the facility's implementation of corrective actions on 04/20/26, the SA	M 000		

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M 000	Continued From page 1 determined the facility had completed the neccessary actions and the Level 4 citation was removed on 4/21/26 prior to the SA entrance on 4/28/26. At the time of the survey, the facility was licensed for 150 beds and had a census of 109 residents.	M 000		
M 640 SS=J	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 Statute is not met as evidenced by: Based on interviews, record reviews, facility's investigation review, and facility policy review, the facility failed to provide a safe environment and failed to protect a resident from a known hazard for one (1) of three (3) residents reviewed for smoking. Resident #1. On 4/18/26 at 9:35 PM, Resident #1, a cognitively impaired resident, ignited a cigarette while receiving oxygen, resulting in a fire and burn injuries that required emergent medical treatment and transfer to a burn center. During the investigation, the SA identified a Level 4 citation which began on 4/18/26. The Level 4 citation existed at Rule 45.21.8 -M640. The facility's failure to provide supervision	M 640		

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M 640	Continued From page 2	M 640		

resulted in serious injury and harm for Resident #1 and was likely to cause serious injury, harm, impairment or death other residents residing in the facility.

The SA notified the facility Administrator of the Level 4 citation on 04/28/26 at 1:50 PM.

Based on the facility's implementation of corrective actions on 04/20/26, the SA determined the facility had completed the neccessary actions and the Level 4 citation was removed on 4/21/26 prior to the SA entrance on 4/28/26.

Findings Included:

Record review of the facility policy, "Resident Non-Smoking Policy" revealed, "Procedure, B, 6. Access to smoking materials will be restricted when oxygen treatment is being administered ...9. All resident and responsible parties will be instructed that all tobacco products or smoking implements must be given directly to facility personnel. 10. Residents are not allowed to keep any smoking materials/tobacco on their person or in their possession. All items will be securely stored and dispersed at designated break times."

Record review of the facility investigation revealed that on 04/18/26 at approximately 9:35 PM, Resident #1 ignited a cigarette while oxygen was in use, resulting in visible flames to the resident's face and upper body.

Record review of hospital discharge records, dated 4/23/35, revealed that Resident #1 sustained second-degree burns to the face, neck, and left hand, requiring emergency response and intubation.

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M 640	Continued From page 3 Interview with Resident #1 on 4/28/26 at 10:00 AM, he initially did not want to discuss the incident that occurred on 4/18/26. Resident #1 then stated that he did attempt to smoke a cigarette in his room and his face and beard caught fire. He stated the staff came in and helped him and sent him to the hospital. He would not say who provided him with smoking paraphernalia [cigarettes, lighter, and two (2) empty vials of tetrahydrocannabinolic acid (THCA) and just said he had a lot of friends. Telephone interview with Licensed Practical Nurse (LPN) #1 on 04/29/26 at 8:00 AM, confirmed that staff entered the room after smelling smoke and observed Resident #1's face on fire. She stated she removed the oxygen and assisted with extinguishing the fire. The resident admitted to her that he was attempting to smoke. Interview with the Administrator on 4/29/26 at 10:06 AM, confirmed that smoking paraphernalia was present in the resident's room at the time of the incident, and that this was a violation of facility policy requiring staff control of such items. Further interview verified that the facility was unable to determine exactly where the resident received the smoking paraphernalia. Record review of the "Face Sheet" revealed that the facility admitted Resident #1 on 12/9/21 with a diagnosis of Chronic Obstructive Pulmonary Disease. Record review of a "Resident Progress Note" dated 4/23/26, revealed a Brief Interview for Mental Status (BIMS) score of three (3), indicating that Resident #1 is severely cognitively impaired.	M 640		

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M 640	Continued From page 4 The facility implemented the following Corrective Action Plan prior to the State Agency's entrance on 4/28/26: On 4/18/26 at 9:34 PM, Certified Nurse Assistant (CNA) #1 and LPN #1 for Resident #1 smelled smoke. LPN # 1 entered room of Resident #1 and called out "He is on fire, call the Ambulance." The oxygen was removed by LPN #1 which stopped the burning. Resident #1 used his hands to help extinguish fire in his beard. LPN #1 assessed Resident #1. Resident #1 was noted to have red area on right side of face, black areas under nose and on bilateral hands and chest. Resident #1 denied any shortness of breath, respirations even and unlabored, oxygen saturation was 96%. Resident #1 did complain of pain to face and hands and was able to talk to staff. On 4/18/26 at 9:35 PM, Registered Nurse Supervisor #1 (RN) called "Code Red" overhead and contacted 911. On 4/18/26 at 9:39 PM, the roommate of Resident # 1 was removed safely from the room by CNA #1 unharmed. He was placed in the Day Area until scene was safe. On 4/18/26 at 9:40 PM, First Responders arrived. LPN #1 remained with Resident #1 until first responders arrived. On 4/18/26 at approximately 9:40 PM, Nurse Practitioner was notified by RN #1 and orders to transport to the Emergency Room were given. On 4/18/26 at 9:45 PM, RN #1 notified the Responsible Party of Resident #1 being sent to the Emergency Room and updated on the	M 640		

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M 640	Continued From page 5 incident. On 4/18/26 at 10:00 PM, RN #1 conducted the initial audit (for smoking related paraphernalia) of the room of Resident #1. RN #1 discovered three packs of cigarettes and a red lighter. These items were removed from the room. On 4/18/26 at 11:21 PM, the Director of Nursing (DON) notified the Mississippi State Department of Health hotline. On 4/19/26 at 9:15 AM, the Administrator and Assistant Director of Nursing (ADON) initiated staff in-service on Resident Non-Smoking Policy. Per the Policy, residents are prohibited from having smoking paraphernalia in their possession. The in-services were conducted with RN's, LPN's, CNAs, Housekeeping, Security, and administrative staff. No staff will be allowed to work until education is completed. On 4/19/26 at 11:00 AM, ADON and RN Supervisor #2 searched the room of Resident #1 along with the rooms and property of three other at risk residents. One open pack of cigarettes and one lighter along with five loose cigarettes and six additional lighters were removed from rooms. On 4/20/26 at 8:00 AM, Staff Education Nurse initiated staff education regarding Fire Safety procedures. The in-service also included classifications for fire extinguishers and RACE (Rescue, Alarm, Contain, Extinguish) and PASS (Pull, Aim, Squeeze, Sweep). On 4/20/26 at 8:50 AM, the current Resident Non-Smoking Policy approved by Mississippi Veterans Affairs on 7/13/23 was reviewed by members of the Interdisciplinary Team, to include	M 640		

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M 640	Continued From page 6 Administrator, Director of Nursing, Assistant Director of Nursing, Social Workers and Nurse Consultant. Upon review, no changes in the Policy were recommended. On 4/20/26 at 9:00 AM, Quality Assurance and Performance Improvement (QAPI) team met. The QAPI meeting occurred on 4/20/26 at 9 am that included the Administrator, DON, ADON / Infection Control Nurse, two (2) Social Workers, three (3) RN Unit Managers, Nurse Consultant, and Medical Director available by phone call. We discussed the notifications of family members, in-services, audits, and purposeful rounding. The QAPI team was in agreement with the performance improvement plan and corrective actions that were put in place. Root Cause Analysis: the event occurred because the resident had access to the cigarettes and lighters in his room and impaired safety awareness. The system failure that we identified was the failure of the facility to effectively enforce the smoking policy. Inadequate visitor control, contraband prevention and failure to ensure all smoking materials were given to staff. Failure to ensure residents are not allowed to keep smoking materials in their possession. On 4/20/26 at approximately 10:00 AM, the Administrator made the area Ombudsman and Veterans Affairs aware of the incident. On 4/20/26 at approximately 1:00 PM, the ADON implemented a Performance Improvement Plan and an Audit Tool related to known and non-compliant smokers. These audits are ongoing and will occur three times per week for two weeks, two times per week for two weeks and one time per week for two weeks. The purpose of the audits are to achieve 100%	M 640		

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M 640	Continued From page 7	M 640		

compliance, per the facility smoking policy. The facility will confiscate any smoking related paraphernalia, and if compliance is not achieved, audits could be increased or extended. Findings will be communicated to the QA committee monthly for the next 90 days. Audits are performed by facility Social Workers, RN's, LPN's or CNA's.

On 4/23/2026 at 12:45 PM, Resident #1 was returned to the facility from the hospital via facility transport. Resident #1 was admitted back to a private room for safety and for infection control purposes. Resident #1 was assessed by RN at each shift change for 72 hours. Resident room assessments, for safety, occur each day for one week, three times a week for two weeks, two times per week for two weeks and weekly for two weeks. These safety assessments began on 4/23/26, upon hospital return, and are ongoing. The safety assessments are completed by the Social Worker, accompanied by an RN, LPN or CNA. Following all visits by RP and/or the person she refers to as her "sitter", documented resident room inspections to occur. Resident is assessed by Nurse related to his wounds, daily.

The facility alleged all corrective measures were fully implemented on 4/20/26 and the Immediate Jeopardy was removed on 4/21/26.

Validation:

The State Agency (SA) validation of the Removal Plan was made on-site during the Complaint Investigation (CI) through record review and observations of all documents supporting the corrective action and staff/resident interviews on 4/29/26. The SA determined all corrective actions were completed on 4/20/26 and the IJ was

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M 640	Continued From page 8 removed on 4/21/26.	M 640		