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 10/03/2022

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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M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI), MS #18643, MS #18721, MS #18843, MS #19536, MS #19610, and MS #19644 at the facility from 9/13/22 through 10/03/22. During the survey, the SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The SA did not substantiate MS #18643 and #18843 related to falls, MS #19610 related to a broken femur, or MS #19644 related to an aggressive resident, but substantiated MS #19536 related to an accident with injury, and MS #18721 related to resident rights, and cited M640 and M500.	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 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;	M 500		

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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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M 500	Continued From page 3 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: Level II	M 500		

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Based on record review, interviews, and policy review, the facility failed to ensure that a resident's privacy was maintained and was treated with dignity and respect in one (1) of six (6) residents reviewed for resident rights. Resident #6

Findings Include:

Record review of the Facility Investigation dated 4/13/22 revealed that on 4/11/22, it was reported to the night registered nurse (RN) supervisor that terminated Certified Nurse Aide (CNA) #1 took a picture of Resident #6 lying on the floor. The caller sent the picture to the facility that was taken of the Resident #6 to an unidentifiable person in a text message. In the message, CNA #1 stated the resident does not listen and used vulgar language to express why the resident was on the floor." The facility investigation included a copy of the picture and text message sent by CNA #1.

Record review of the facility provided "PHONE USE POLICY" dated 5/13/22, stated ..."Cell phone use in resident care areas are prohibited except in cases of actual emergency" ...

Record review of the personnel file of CNA #1 revealed she received her certification from the state Nurse Aide Registry on 9/30/16. Further review revealed she was terminated by the facility on 4/05/22 with "REASON FOR TERMINATION: Employee left the facility without proper permission."

Record review of the Face Sheet for Resident #6 revealed he was admitted to the facility on 2/23/22. His diagnoses include Chronic Kidney Disease, Type 2 Diabetes, Hypertension, Abnormalities of Gait and Mobility, Lack of

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Coordination, Cognitive Communication Deficit and History of Trans Ischemic Attacks and Cerebral Infarction.

Record review of the Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/29/22, for Resident #6 revealed he had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated no cognitive impairment. Further review revealed Resident #6 required limited one-person assistance for surface-to-surface transfers, dressing, toilet use, and personal hygiene; he required supervision for bed mobility and set-up assistance for eating; he was not ambulatory and required a wheelchair for locomotion.

On 9/14/22 at 2:30 PM, an interview with the Director of Nurses (DON) revealed that on 4/11/22 the facility received a report by telephone that a photograph had been taken of Resident #6 and texted to an outside party. The Administrator stated the CNA #1's employment at the facility had been terminated. The DON stated it was considered a breach of Resident Rights and an invasion of Resident #6's dignity for staff to photograph him and to text the photograph to any outside entity. The DON stated the facility had provided in-service training to all staff regarding Resident Rights monthly.

On 9/14/22 at 2:45 PM, an interview with the Administrator revealed that on 4/11/22 the facility received a report by telephone that a photograph had been taken of Resident #6 and texted to an outside party. The Administrator stated the CNA #1's employment at the facility had been terminated. The Administrator stated it was considered a breach of Resident Rights and an invasion of Resident #6's dignity for staff to

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M 500	Continued From page 6 photograph him and to text the photograph to any outside entity. She stated the unknown person to whom the photograph had been sent provided the photograph to her through a text message.	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 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 II Based on record review, interviews, and policy review, the facility failed to prevent a fall during a mechanical lift transfer for one (1) of four (4) residents reviewed for injuries related to use of mechanical lifts. Resident #3 Findings Include: Record review of the Facility Investigation dated 8/27/22, confirmed the Facility investigated an unreported fall of Resident #3. The Facility Investigation included a statement by Certified Nurse Aide (CNA) #3 in which she stated CNA #2 asked her to assist with lifting Resident #3 from the floor. Licensed Practical Nurse (LPN) #1 provided a written statement in which she stated CNA #2 notified to her that Resident #3 had hit his left toe on the lift, resulting in an abrasion. In the statement made by LPN #1, she stated she performed a body audit on Resident #3 that revealed no other injuries and placed a small	M 640		

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bandage on the left toe abrasion.
The Facility Investigation revealed staff reported they heard Resident #3 had fallen during a surface-to-surface transfer with a mechanical sit to stand lift when CNA #2 attempted the transfer without assistance. Resident #3, his wife, and other direct care staff were interviewed, and it was determined that on 8/27/22, Resident #3 experienced an unreported fall.

Record review of the personnel file for CNA #2, revealed the CNA received certification from the state Nurse Aide Registry on 7/26/22. Further review revealed she was terminated by the facility on 9/01/22, with "REASON FOR TERMINATION: Terminated due to not reporting a fall of a resident."

Record review of the "User Manual Stand Up Patient Lift" (undated) stated, " ...The use of one assistant is based on the evaluation of the health care professional for each individual case ..."

Record review of the "Initial Education and Competency Checklist" dated 8/19/22 revealed CNA #2 was provided in-service training for "Topic/equipment: Portable Lift ...Topic/Equipment: Stand Assist," and completed competency checkoff, signed by the staff education nurse.

Record review of the Face Sheet for Resident #3 revealed he had been admitted to the facility on 2/28/222. The resident's diagnoses include Dementia, Diabetes, Cerebral Infarction and Hemiplegia.

Record review of the Care Plan for Resident #3 revealed a Care Plan stating, " ...Requires Assistance with ADL's R/T Hemiplegia, Muscle

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Weakness ... Care Plan Goal: Resident will be provided with staff assistance as needed which will allow for successful ADL completion ...". Interventions included "Transfer to bed or chair with total assistance of staff x 2" with "Roles" listed as "Nursing Assistant."

Record review of the Quarterly Minimum Data Set for Resident #3 with an Assessment Reference Date (ARD) date of 9/14/22, revealed a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated moderate cognitive impairment. Further review revealed Resident #3 required extensive one person assistance for bed mobility and was dependent on two-person assistance for surface-to-surface transfers.

On 9/14/22 at 10:50 AM, an interview with LPN #2/Staff Education Coordinator, she stated the nursing staff receive training on following care plans and the correct procedure for the use of lifts during orientation and at least annually. She stated all CNAs are required to complete competency checkoffs for transfers. She confirmed that CNA #2 had received the training on the use of mechanical lifts and exhibited competency in checkoff on 8/19/22. LPN #2 stated the in-service training included notification of the nurse if there were any problems during transfers.

On 9/14/22 at 2:30 PM, an interview with the Director of Nurses (DON) revealed that a facility investigation determined that Resident #3 had experienced an unreported fall on 8/27/22. The investigation revealed the fall occurred when CNA #2 attempted to transfer Resident #3 with a sit to stand lift without assistance. The CNA did not report the fall but reported to LPN #1 that the resident hit his toe on the lift and had a small

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M 640	Continued From page 9 abrasion. CNA #2's employment at the facility was terminated, due to failure to report a fall. On 9/14/22 at 2:45 PM, an interview with the Administrator revealed that on 8/27/22, CNA #2 had notified LPN #1 that Resident #3 his hit toe on a lift and had a small abrasion. Staff reported later that day that they believed Resident #3 fell when CNA #2 performed a surface-to-surface transfer with a sit to stand lift without assistance. The Administrator revealed the investigation confirmed Resident #3 had experienced an unreported fall on 8/27/22. The Administrator stated that CNA #2's employment at the facility was terminated following the investigation, for not reporting a fall.	M 640		