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 02/16/2023

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 an annual survey along with a Complaint Investigation (CI MS# 20599, CI MS# 20588, CI MS#20582, and CI MS# 20352) at the facility from 2/13/23 through 2/16/23. During the survey, the SA determined that the facility was not in compliance with the Minimum Standards for Institutions for Aged or Infirm,state licensure requirements. The SA identified non-compliance and cited M500 for CI MS# 20582 for failure to provide the residents the right to appropriate and safe care. There were no deficiencies cited for CI MS#20599 and CI MS #20588 related to allegations of abuse and CI MS#20352 related to a residents attempted elopement. The census at the time of the survey was 136 with a bed capacity of 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	M 500		

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M 500	Continued From page 1 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 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	M 500		

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M 500	Continued From page 2 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 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	M 500		

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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 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

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M 500	Continued From page 4 the fullest exercise of these rights. This Statute is not met as evidenced by: Level III Based on observations, staff interviews, record review and facility policy review, the facility failed to ensure a resident received adequate and appropriate medical care as evidenced by Licensed Practical Nurse #1 not following the physician's order related to blood sugar monitoring, insulin administration, and notification of the physician for one (1) of three (3) residents reviewed. Resident #1 Findings include: Record review of the facility policy titled "Mississippi VA (Veterans Administration) RESIDENTS RIGHTS, dated March 11, 2022, revealed, "The Resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including each of the following rights: ...D. Free Choice: The Resident has the right to ... 2. Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's wellbeing." Record review of the facility policy titled "MEDICATION ADMINISTRATION", dated March 30, 2022, revealed " ...2.GENERAL: All medications shall be administered only as prescribed ...The time and dose of medication administration is to be recorded in the patient's medication administration record at the time it is administered by the licensed person who give the dose .... 4.PROCEDURE ... 6.The nurse	M 500		

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administering the medication is to document in the patient's electronic health record for the correct drug, dose, and time of administration ...."

Record review of the facility policy titled "ACCU-CHECK POLICY", dated January 15, 2013, revealed, " ...3.PURPOSE: The purpose of this policy is to describe the use of accu-checks at this facility. PROCEDURE: 1. With specific physician's orders: routinely and/or PRN, 2. Without specific physician's orders: in the event of a medical emergency, implement standing order for FSBS (Finger Stick Blood Sugar). DOCUMENTATION: 1. Document the results of accu-check ... 2. Contact the physician of abnormal values as per a. Specific orders on a residents chart, b. Facility protocol for hyper/hypoglycemic episodes, 3. Document physician contact, action taken and outcome in the nurses notes ...."

Record review of facility policy titled "DIABETIC PROTOCOL POLICY", dated January 15, 2013, revealed, " ...2. GENERAL:Individuals with diabetes sometimes have episodes in which their blood sugar dips too low (hypoglycemia) or spikes too high (hyperglycemia). Residents that experience these episodes will be cared for accordingly. 3. PURPOSE: The purpose of this policy is to explain what steps to take when a resident is having a hypoglycemic or hyperglycemic episode ....REMINDERS ...2. HYPERGLYCEMIC EPISODES: For residents experiencing hyperglycemic episodes, Perform finger stick as needed (prn) when signs/symptoms warrant; Follow standardized sliding scale (unless otherwise ordered); if no order for sliding scale insulin to be administered, notify physician; if finger stick blood sugar is greater than 400, notify doctor for orders (unless

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specific orders have been given); recheck blood sugar 2 hours after giving insulin per sliding scale for effectiveness of insulin; If blood sugar is still elevated, do not give additional insulin without calling MD first; Document vital signs, mental status, describe signs/symptoms, all interventions provided to the resident, if MD notified, list time/orders ..."

A phone interview with Licensed Practical Nurse (LPN) #1 on 2/14/23 at 11:30 AM, revealed that on 1/21/23, she was the nurse passing medications on Resident #1's hall when he had to be transferred to the hospital for hypoglycemia. She stated she thought he was scheduled for a blood sugar check, so around 8:00 - 8:30 AM she checked his blood sugar and the resident's level was very high. The glucometer read the result of "HI" and did not give a blood sugar level number. When she got that result, she did not recheck his blood sugar with that glucometer or with another glucometer. The Nursing Supervisor was busy, so she administered Resident #1 20 units of insulin so his blood sugar level could come down. She confirmed she did not notify a Registered Nurse (RN), the supervisor, or the doctor. She revealed she did not document the glucose result or the administration of the insulin in the nurses notes. She also revealed she was unable to document the blood sugar result and insulin administration in the electronic medication administration record due to the requirement to enter the blood glucose level before the sliding scale insulin amount could be documented. She stated she was unable to enter a blood sugar level since the meter read "HI". She stated that "a while" after she gave the resident insulin, "he started not acting right" and was less responsive. She stated she rechecked his blood sugar and the result was "around 81", and since "he was not responsive and did not

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look well", she got the other supervisor to come and check him and the paramedics were called. Another blood sugar check revealed a blood sugar level in the 30s. She stated she tried to give him some oral glucose, but it "just ran out of his mouth". The paramedics arrived and the resident was taken to the hospital. She stated she initially told the supervisor and the Emergency Medical Technicians and wrote in her statement that she gave 30 units, but then she thought about it and realized "30 units would be too much, so I must have given about 20 units." She stated she had only worked at this facility for a short period of time, but she had worked with Resident #1 many times. She confirmed she did not follow the physician's orders for the blood sugar check, insulin administration, or for notifying physician for increased blood sugar level. She confirmed she did not document properly. She stated she had been in-serviced on documentation, following physician's orders, medication administration, use of glucometer, and sliding scales. She confirmed that by not following the physician's orders, she did not give safe and appropriate care to this resident. She confirmed she should have followed the physician's orders and the policies of the facility.

An interview with the Administrator on 2/14/23 at 2:00 PM, revealed LPN #1 did not follow the physician's orders and was terminated. She stated when the incident occurred, LPN #1 gave different accounts of what had occurred with Resident #1. She stated the staff were notified of the resident's low blood sugar level and called paramedics and the resident was transferred to the hospital. She stated LPN #1 gave different statements of the condition of the resident and the amount of insulin she gave. The Administrator stated she completed her shift that Saturday, and

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by Monday when they had put the pieces together of what had happened. LPN #1 came in and was suspended pending investigation. She stated LPN #1 was not allowed to work after the day of the incident.

An interview on 2/14/23 at 2:15 PM, with RN #1 revealed on 1/21/23, she came into work around lunch time and worked as an RN Supervisor. She stated that LPN #1 came to her around noon and told her that Resident #1 was not acting right, and she wanted her to check on him. She went to check Resident #1 and he could not focus, and his glucose was in the 80s. RN #1 left the room to call the paramedics and when she went back into the room, the resident was sweating. RN #1 told LPN #1 to recheck his glucose level and it was in the 30s. She stated LPN #1 tried to give the resident oral glucose, but he was unable to swallow. LPN #1 gave report to the paramedics and told them that that morning the resident's blood sugar was high and she gave him 30 units of insulin. RN #1 stated that was a "red flag" for her since their sliding scales only goes to 25 units, but at that time she was unaware that the physician had not been contacted. The resident was taken to the hospital for treatment. RN #1 stated that LPN #1 told her that the resident was not acting right that morning so she checked his blood sugar and it read "HI", so she gave the resident 30 units of insulin. She stated that LPN #1 came to her later and told her she did not give 30 units, but she gave 20 - 25 units. She stated LPN #1 initially wrote a statement which revealed 30 units were given then she wrote another statement that indicated 20 units were given. She stated LPN#1 told her she could not document the insulin in the electronic medication administration record since it would not allow her to chart the "HI" level since this was not an

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indicator on the sliding scale and for a high level, the physician was to be notified. RN #1 stated after this, she checked with the Director of Nursing (DON) who was working that morning as a supervisor to see what had occurred and what orders had been given by the physician, and the DON had no idea of what had happened. She stated the DON told her that she was not notified by LPN #1 of any concerns of Resident #1 acting differently, having a high blood sugar, or administering insulin without an order. RN #1 stated the proper procedure would have been to recheck a glucose level that was high and notify the physician as ordered. She stated some LPNs will contact the physician, but others will contact the supervisor and have them contact the physician, but the physician must be notified as ordered.

An interview on 2/14/23 at 2:35 PM, with the DON revealed she was the nursing supervisor on 1/21/23 until around lunch time. She stated she was busy that morning and she saw LPN #1 at the desk around 11 AM, but LPN #1 never mentioned any concerns with Resident #1's change of condition or high blood sugar. The DON stated she was not aware of anything going on with the resident until RN #1 asked her about the change in condition and the new orders for Resident #1. She stated as they investigated what occurred, they were able to put the pieces together and they realized the physician had not been notified and that no documentation had been entered. The DON stated she asked LPN #1 what was going on with Resident #1 that indicated a need for a blood sugar check since his were only ordered weekly on Wednesday. LPN #1 told her, "I always checked his blood sugar" and "it was high". The DON said at first, LPN #1 had told staff and paramedics she had

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M 500	Continued From page 10 given 30 units of insulin, but then she looked at the syringe and said, "No, it wasn't 30 units, the plunger of the syringe wasn't drawn back far enough for 30 units, so I gave like 20 units". She stated for a high blood sugar range the nurse is supposed to notify the physician and for those levels that are reading "high" on the meter. The physician must be notified and will give an order for the resident's treatment. The DON confirmed that LPN #1 failed to follow the physician's orders and failed to contact the physician as ordered. She stated the system for administering medication has built in safety features and if a sliding scale is ordered, the blood sugar level has to be entered into the electronic medication administration record and then the system calculates the correct amount of insulin to be administered. This is then documented into the electronic medication administration record system. She stated LPN #1 did not document the resident's condition, glucose level, or the insulin administered in this system or in the nurses notes. She stated the resident was hypoglycemic and required hospitalization. She confirmed the systems were in place for safe and appropriate care, but this nurse went around the system and administered medication without an order, therefore the care received by the resident was not safe or appropriate. An interview with the onsite facility pharmacist on 2/15/23 at 3:00 PM, revealed the facility's medication system and the electronic medication administration record system have measures put in place to prevent errors from occurring. He stated from what he understands, the nurse just "messed up" and bypassed the safety features of the system and administered medications without an order.	M 500		

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M 500	Continued From page 11 An interview with the Administrator on 2/16/23 at 8:45 AM, confirmed LPN #1 made a medication error and administered insulin to Resident #1 without following physician orders or notifying physician and the resident had to receive additional care in the hospital. She confirmed there was a potential for greater harm for the resident. The Administrator confirmed that each person has the right to appropriate and safe care and to have knowledgeable staff caring for them. She also confirmed that each resident and family should have the confidence to know that knowledgeable staff that follow physician's orders and make good care choices are providing their care. She confirmed the facility failed to ensure appropriate and safe care was given to Resident #1. Record review of LPN #1's New Hire Orientation Check Off List dated 10/14/22, revealed LPN was checked off on resident's right, dignity and respect and medication review. Record review of LPN #1's Skills, Knowledge Inventory for RNs and LPNs dated 11/1/22 revealed she was trained on preparing administering and recording medications and on charting observations behavior, progress, regression, etc. Record review of Medication Review dated 10/14/22 revealed ability to answer the five rights when administering medications as resident, route, time, dosage, and medication. Record review of the Licensed Practical Nurse Scope of Practice dated 10/14/22 revealed the LPN was trained on "a. Respecting the rights of the patient which includes but is not limited to: ... 2. Respecting the dignity and rights of patients	M 500		

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regardless of social or economic status, personal attributes or nature of health problems. ...c. Observing, recording, and reporting to the appropriate persons the signs and symptoms which may be indicative of change in the patient's condition".

Record review of Medication Pass Evaluation dated 11/1/22 revealed LPN was observed with "8. Medication administration ...c. Nurse verifies medication and strength with order as transcribed on medication record per facility policy ...h. correct dose is administered ...16. Resident's rights are observed."

Record review of the Personnel Action form dated 1/23/23 revealed the reason for action was violation of Company rules, defective and improper work, and carelessness. The form was signed by LPN #1.

Record review of Resident #1's "Discharge Summary" with a discharge date of 1/23/23 at 9:01 AM revealed " ...Admission Diagnosis: Hypoglycemia ... History of Present Illness/Hospital Course ...from VA nursing home ... to the emergency room on 1/21/23 with altered mental status. By history, patient received 30 units of insulin at the nursing home, unsure of what type of insulin ..."

Record review of Physician Orders for January 2023 revealed an order dated 10/3/22 "Accuchecks weekly" and "Sliding scale with Regular Insulin as follows: Less than (<)70 = Hypoglycemic Protocol; 70-200 = 0 units; 201 - 250 = 5 units; 251 - 300 = 10 units; 301 - 350 = 15 units; 351 - 400 = 20 units; 401 - 450 = 25 units; Call MD (Medical Doctor) for BS (Blood Sugar) greater than 450. Recheck BS every 3

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	04KO	A. BUILDING: _____ B. WING _____	C 02/16/2023

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MS STATE VETERANS HOME-KOSCIUS	310 AUTUMN RIDGE DRIVE KOSCIUSKO, MS 39090

(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 500	Continued From page 13 hours. Do not give additional SS (sliding scale) @ (at) 3-hour mark." Record review of the January 2023 Electronic Medication Administration Record revealed the resident was not scheduled for a blood sugar check on 1/21/23 (Saturday). The blood sugar checks were scheduled on Wednesday. No record or documentation noted on 1/21/23 for an accucheck or administration of insulin. Record review of the Face Sheet for Resident #1 revealed he was admitted to the facility on 10/3/22 with diagnoses that included Type 2 Diabetes Mellitus, Cerebral Infarction and Depression. Record review of quarterly Minimum Data Set with an Assessment Reference Date of 1/4/23, revealed a Brief Interview for Mental Status score of 10 which indicated mild cognitive impairment.	M 500		