Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, resulted from the State Veterans Home (SVH) Survey as a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or applicable Life Safety Code Identifying Information.) Title 38 Code of Federal Regulations Part 51 is applied for SVHs applicable by level of care.

General Information:

Facility Name: Mississippi Veterans Home – Jackson

Location: 4607 Lindbergh Dr., Jackson, MS 39209

Onsite / Virtual: Onsite

Dates of Survey: 9/17/24 – 9/20/24

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 100

Census on First Day of Survey: 90

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from September 17, 2024, through September 20, 2024, at the Mississippi Veterans Home – Jackson. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.120 (j) Nutrition. Based on a resident's comprehensive assessment, the facility management must ensure that a resident— (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when a nutritional deficiency is identified **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observations, interviews, record reviews, and facility policy review, the facility failed to provide interventions as planned or to provide assistance for two (2) of four (4) residents reviewed for weight loss (Resident #1 and Resident #3). The findings include: Review of the facility policy titled, "Weight Loss Prevention Program," dated 9/9/23, revealed: "General: The Mississippi State Veterans Home must ensure that a resident maintains acceptable parameters of nutritional status to maintain a healthy weight and prevent weight loss." Review of Resident #1's clinical record revealed an admission date of [DATE], and had diagnoses which included Parkinsonism, Ataxia, Unspecified Protein-Calorie Malnutrition, and Tremors. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated

	intact cognition. The resident required set-up/cleanup with eating, had weight loss, which was not physician prescribed, and had not received nutritional approaches. Review of Resident #1's Care Plan, dated [DATE], included the following nutritional interventions: [DATE] – Dietary Staff A to evaluate and make diet change recommendations as needed. Staff were to provide and serve diet and supplements as ordered and monitor intake and record every meal. Resident #1 to feed themselves after setup assist. Staff directed to encourage resident's participation and independence with activities of daily living (ADLs) but assist as needed. [DATE] – Staff were to provide regular diet with regular texture with thin liquids. Staff to encourage resident to have good nutritional and fluid intakes. Obtain and monitor weights as ordered. Dietary Staff A to evaluate nutritional status quarterly or as needed and provide updated recommendations. Staff to set up tray and resident to feed self. [DATE] – Weighted utensils related to tremors. Review of the Certified Nurse Aide Tool Sheet (identified as a form to inform them of the residents' requirements for eating, showers, and transfers), updated on [DATE], found it did not list the weighted utensils for Resident #1. Review of Resident #1's Weight List revealed: [DATE] – 163.3 pounds (lbs.) [DATE] – 160 lbs. [DATE] – 155.6 lbs. [DATE] – 158.7 lbs. [DATE] – 154 lbs. [DATE] – 159.6 lbs. [DATE] – 146 lbs. [DATE] – 142.4 lbs. [DATE] – 141.8 lbs. [DATE] – 140.8 lbs. The above represented 22.8 lbs. or a 13.78 percent weight loss from [DATE] to [DATE]. [DATE] - 142.6 lbs. [DATE] – 141 lbs. [DATE] – 139.2 lbs. The above represented 19.5 lbs. or a 12.28 percent weight loss from [DATE] to [DATE].

	Review of Resident #1's Physician Orders revealed: [DATE] – Assorted snack to be provided at 2:00 p.m. [DATE] – Ham and cheese sandwich provided at 10:00 a.m. [DATE] – Fortified cheese grits at breakfast and Boost (nutritional supplement) at 10:00 a.m., for 30 days. [DATE] – Weighted utensils related to tremors. [DATE] – Discontinued ham and cheese sandwich at 10:00 a.m. [DATE] – Assorted diabetic snacks provided at 2:00 p.m., and at 8:00 p.m. [DATE] – Snack of choice to be provided at 10:00 a.m., for 30 days. Review of Resident #1's Nutritional Assessments and Dietary Staff Notes revealed: [DATE] – Resident's weight 160 lbs., and their body mass index (BMI) was 21, which indicated the resident was classified as underweight for the elderly population. The resident received a regular texture diet and ate 75 to 100 percent (%) of most meals. [DATE] – Resident had a four-point four (4.4) lb. weight loss. Recommend assorted snacks at 2:00 p.m., for additional calories. [DATE] – Resident had lost 8.52 % of weight. Recommended fortified cheese grits at breakfast and Boost at 10:00 a.m., for 30 days. [DATE] – Resident #1 ate outside food from a friend. [DATE] – Staff had no concerns during the resident's mealtimes. No recommendations made. [DATE] – Resident #1 had a significant weight change this quarter; loss 8.52 %. The resident consumed 60% of most meals and had no issues with chewing/swallowing. Recommended weighted utensils related to tremors needed. Will continue to follow up and monitor resident's nutritional needs. [DATE] – The resident's weight was stable, and they were able to make their needs known. No recommendations made. In an interview with Resident #1, on 9/17/24, at 11:04 a.m., regarding their weight loss, they stated they were a "meat eater and chicken was not meat." Review of the [DATE] Medication Administration Record (MAR), on 9/20/24, at 8:39 a.m., revealed staff documented the resident received weighted utensils at each meal. Observation, on 9/17/24, at 12:19 p.m., revealed the resident had received their lunch tray in their room. Further observation revealed the resident received a cheeseburger, but had not received the weighted utensils.

	Observation, on 9/18/24, at 11:55 a.m., revealed Resident #1 had received their lunch tray in their room. Further observation revealed the resident received fried chicken, but did not receive the weighted utensils. Review of the diet slip on Resident #1's tray revealed the resident should have received "weighted utensils." Observation, on 9/18/24, at 12:37 p.m., revealed the resident did not eat the fried chicken, and staff did not offer a substitute. Observation, on 9/19/24, at 11:57 a.m., revealed the resident received their lunch tray in their room. The resident received beef brisket, but did not receive the weighted utensils. The resident asked the surveyor to cut their meat. The surveyor notified staff that the resident wanted assistance to cut their meat. In an interview with Licensed Nurse A, on 9/19/24, at 12:03 p.m., they stated that if a diet slip listed a resident should have weighted utensils, then they should have received them on their tray. Licensed Nurse A went to the [LOCATION] and brought back weighted utensils for the resident. In an interview with Resident #1, on 9/19/24, at 12:13 p.m., the resident stated they guessed it was easier eating with the new (weighted) silverware. In an interview with Dietary Staff A, on 9/19/24, at 12:54 p.m., they stated the weighted utensils should have come on the resident's food tray from the [LOCATION]. Dietary Staff A stated snacks of choice and assorted snacks were the same thing. The snacks consisted of Oreo's, oatmeal pies, chips, Cheez Its, and Jello. Diabetic snacks consisted of sugar free ice cream, Jello, pudding, fruit cups, and a half a sandwich. In an interview with Administrative Nurse A, on 9/19/24, at 2:05 p.m., they stated the night shift licensed nurse was who updated the Certified Nurse Aide Tool sheets. In an interview with Licensed Nurse B, on 9/20/24, at 9:21 a.m., they stated Dietary Staff A wrote their recommendations on a communication form. The nurse would write the recommendation on an order sheet, and when the physician signed the order sheet, the nurse would put it in the computer and then it would come up on the MAR for the nurses to follow up on the order. The nurse would sign off on the MAR after the intervention was completed or the supplement was given. Review of Resident #3's clinical record revealed an admission date of [DATE], and diagnoses included Dementia, Coronary Atherosclerosis, and Hypertension.

	Review of Resident #3's MDS, dated [DATE], revealed a BIMS score of four (4), which indicated severe cognitive impairment. The MDS revealed the resident required set-up/clean-up assistance with eating, weighed 170 pounds, had no or unknown weight loss, and did not receive nutritional approaches. The MDS documented the resident received Speech Therapy (ST), Occupational Therapy (OT), and Physical Therapy (PT) services and was on hospice. Review of the Hospice Certification revealed Resident #3 received hospice services because of a diagnosis of Senile Degeneration of the Brain. Review of Resident #3's Care Plan, dated [DATE], listed the interventions: [DATE] – Set-up assist for eating meals and encourage resident's participation and independence with ADL's but assist as needed. [DATE] – Provide snacks and supplements as ordered. Boost with all meals for 30 days for additional calories. Encourage the resident to have good nutritional intake. Encourage the resident to have good fluid intake. Weigh monthly. Obtain and monitor weights as ordered and notify physician and Dietary Staff A of significant weight changes. Dietary Staff A to evaluate nutritional status quarterly or as needed and provide updated recommendations. [DATE] – Give water with every meal and no tea. Review of the Certified Nurse Aide Tool sheet, dated [DATE], revealed that Resident #3 fed themselves. Review of Resident #3's Weight List revealed: [DATE] – 167.8 lbs. [DATE] – 170 lbs. [DATE] – 160 lbs. [DATE] – 160 lbs. [DATE] – 160.8 lbs. [DATE] – 157 lbs. [DATE] – 155.6 lbs. The above represented 12.2 lbs. or a 7.27 % weight loss in one (1) month from [DATE] to [DATE]. [DATE] – 156.4 lbs. [DATE] – 157 lbs. [DATE] – 154.4 lbs. [DATE] – 156.2 lbs. [DATE] – 155.4 lbs.

	The above represented 12.4 lbs. or a 7.38 % weight loss from [DATE] to [DATE]. Review of Resident #3's Physician Orders revealed: [DATE] – Weight monthly and regular diet. [DATE] – Assorted snack at 2:00 p.m. [DATE] – Ice cream with all meals for 30 days and Boost with all meals for 30 days. [DATE] – Give water with each meal and no tea. [DATE] – Intake and output every shift. Review of the Dietary Staff Note, dated [DATE], revealed Resident #3 had a 10 lb. weight loss. The resident's weight and appetite were expected to fluctuate, and Dietary Staff A recommended Boost with all meals. Review of a Dietary Staff Note, dated [DATE], revealed the resident's weight was stable and no recommendations were made. Review of a Dietary Staff Note, dated [DATE], revealed Resident #3 had a four (4) lb. weight loss, and Dietary Staff A recommended a snack at 10:00 a.m. Review of a Dietary Staff Note, dated [DATE], revealed the resident's weight was stable and no recommendations were made. Review of a Dietary Staff Note, dated [DATE], revealed the resident's weight was stable and no recommendations were made. Review of a Dietary Staff Note, dated [DATE], revealed the resident's weight was stable and no recommendations were made. Review of a Dietary Staff Note, dated [DATE], revealed staff received a new order for Resident #3 for Boost and ice cream with all meals. Review of a Dietary Staff Note, dated [DATE], revealed the resident's weight was stable and no recommendations were made. Review of a Dietary Staff Note, dated [DATE], revealed Resident #3's weight was stable. The note further revealed the resident loved hamburgers and would like to have them more often. The note also revealed Resident #3's representative "would like for resident to have assistance during mealtimes." No recommendations were made.

	Review of a Dietary Staff Note, dated [DATE], revealed the resident's weight was stable and no recommendations were made. Review of the "Diet/Snack Supplements Audit," dated [DATE], revealed that Resident #3 should have received: "Ice cream with all meals; clarify: move from supplements to DTY [dietary]." This audit was completed by the facility's Dietary Staff A and Dietary Staff B. Review of Resident #3's diet slip revealed the staff were to assist the resident by cutting up all whole meats served to them. Observation, on 9/17/24, at 12:24 p.m., revealed Resident #3 received their lunch tray. The resident received a carton of vitamin D milk, potato salad, a roll, mixed vegetables, barbeque chicken, water, peach cobbler, and chocolate Boost. Further observation revealed the staff did not provide the ice cream to the resident as planned. Observation, on 9/17/24, at 1:05 p.m., revealed that staff did not cut up the barbeque chicken served for Resident #3, and the resident did not eat the chicken. The resident ate the peach cobbler, approximately two (2) spoonsful of potato salad, and drank water. Further observation revealed that the staff had not provided assistance for the resident to eat. Observation, on 9/18/24, at 12:01 p.m., revealed a staff member served Resident #3 their lunch tray while in bed. The resident received fried chicken, mashed potatoes and gravy, coleslaw, a biscuit, sweet potato pie, iced tea, coffee, vitamin D milk, and vanilla Boost. The staff did not serve the resident ice cream as planned, and did not follow the Physician Order to not serve iced tea to Resident #3. The staff did not cut up the fried chicken, or stay with the resident during the meal to provide them assistance. Observation, on 9/18/24, at 12:39 p.m., revealed the resident ate approximately 1/3 (one third) of their mashed potatoes and gravy, 1/2(one-half) of their biscuit, drank all of their coffee and tea, and ate their chicken, but not the skin. Observation, on 9/19/24, at 12:03 p.m., revealed staff served the resident their lunch tray. Resident #3 received chocolate Boost, whole milk, brisket, loaded potatoes, Ambrosia fruit salad, steamed cabbage, and a bottle of water. The resident tried to cut their brisket with their fork, but could not. The resident held the piece of brisket up with their fork and tried to bite off a piece of the meat at the bottom. A staff member sat down at the table with Resident #3 and another resident. The staff member did not cut up the meat, and did not provide Resident #3 assistance to eat their meal.

	Observation, on 9/19/24, at 12:34 p.m., revealed Resident #3 ate one (1) bite of meat, approximately 50% of their potatoes, 20% of their Boost, and 90% of the water. Further observation revealed that the staff did not provide the resident with ice cream. In an interview with Licensed Nurse A, on 9/19/24, at 12:03 p.m., they stated that if a resident's diet slip listed an intervention, then the staff should have provided that intervention. In an interview with Dietary Staff A, on 9/1/24, at 12:54 p.m., they stated their recommendations went into the Physician's Book. When approved by the physician, Dietary Staff A would add them into the computer system, and it would automatically go onto the diet slip. Dietary Staff A also stated the nursing staff were responsible for cutting up Resident #3's meat at mealtime. In an interview with Administrative Nurse A, on 9/19/24, at 2:05 p.m., they stated the night shift licensed nurse updated the Certified Nurse Aide Tool sheets. In an interview with Licensed Nurse B, on 9/20/24, at 9:21 a.m., they stated Dietary Staff A wrote their recommendations on the communication form. The nurse would write the recommendation on an order sheet, and when the physician signed the order sheet, the nurse would put it in the computer and then it would come up on the MAR for the nurses to follow up on the order. The nurse would sign off on the MAR after the intervention was completed or the supplement was given.
§ 51.140 (g) Assistive devices. The facility management must provide special eating equipment and utensils for residents who need them. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observations, interviews, and record review, the facility failed to provide weighted utensils for one (1) of one (1) resident reviewed for assisted devices (Resident #1). The findings include: Review of Resident #1's clinical record revealed an admission date of [DATE], and diagnoses which included Parkinsonism, Ataxia, Unspecified Protein-Calorie Malnutrition, and Tremors. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The resident required set-up/cleanup with eating, had weight loss which was not physician prescribed, and had not received nutritional approaches. Review of Resident #1's Care Plan, dated [DATE], included the intervention for weighted utensils related to tremors with the start date of [DATE].

	Review of the Certified Nurse Aide Tool Sheet (identified as a form to talk about the residents' requirements for eating, showers, and transfers), updated [DATE], did not list the weighted utensils for Resident #1. Review of Resident #1's Physician Orders revealed an order, dated [DATE], for weighted utensils related to tremors. Observation, on 9/17/24, at 12:19 p.m., revealed Resident #1 had received their lunch tray in their room. Further observation revealed the resident had not received the weighted utensils. Observation, on 9/18/24, at 11:55 a.m., revealed Resident #1 had received their lunch tray in their room. Further observation revealed the resident did not receive the weighted utensils. Review of the diet slip on Resident #1's tray revealed the resident should have received "weighted utensils." Observation, on 9/19/24, at 11:57 a.m., revealed Resident #1received their lunch tray in their room. Resident #1 had not received the weighted utensils. In an interview with Licensed Nurse A, on 9/19/24, at 12:03 p.m., they stated if the diet slip listed a resident should have weighted utensils, then they should have received them on their tray. Licensed Nurse A went to the [LOCATION] and brought back weighted utensils for Resident #1. In an interview with Resident #1, on 9/19/24, at 12:13 p.m., the resident stated they guessed it was easier eating with the new (weighted) silverware. In an interview with Dietary Staff A, on 9/19/24, at 12:54 p.m., they stated the weighted utensils should come on the resident's food tray from the [LOCATION]. In an interview with Administrative Nurse A, on 9/19/24, at 2:05 p.m., they stated the night shift licensed nurse updated the Certified Nurse Aide Tool sheet.
51.200(b) Emergency Power. (1) An emergency electrical power system must be provided to supply power adequate for illumination of all exit signs and lighting for the means of egress, fire alarm and medical gas alarms, emergency communication systems, and generator task illumination.	Based on record review, observation, and interview, the facility failed to properly inspect and test all components of the emergency generator as required by the code. The deficient practice affected 12 of 12 smoke compartments, staff, and all residents. The facility had the capacity for 100 beds with a census of 90 on the first day of the survey. The findings include: Record review, on 9/17/24, at 10:50 a.m., of the monthly emergency generator inspection and testing records dating back 12 months prior to the survey, revealed the facility failed to

(2) The system must be the appropriate type essential electrical system in accordance with the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. (3) When electrical life support devices are used, an emergency electrical power system must also be provided for devices in accordance with NFPA 99, Health Care Facilities Code. (4) The source of power must be an on-site emergency standby generator of sufficient size to serve the connected load or other approved sources in accordance with NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	perform specific gravity or conductance testing during monthly generator inspections, as required by section 8.3.7.1 of NFPA 110, Standard for Emergency and Standby Power Systems. An interview, on 9/17/24, at 10:55 p.m., with Maintenance Staff A revealed the facility previously replaced their generator batteries with sealed “maintenance free” type batteries, and were unaware of any monthly testing requirements for those batteries. Observation during the facility tour, on 9/17/24, at 11:30 a.m., revealed two (2) 350-Kilowatt emergency generator, each containing two (2) unsealed, maintenance type, lead acid batteries. The census of 90 was verified by Maintenance Staff B on 9/17/24, at 9:30 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the LSC exit interview on 9/17/24, at 4:00 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** 19.5 Building Services. 19.5.1 Utilities. 19.5.1.1 Utilities shall comply with the provisions of Section 9.1. 9.1.3 Emergency Generators and Standby Power Systems. Where required for compliance with this Code, emergency generators and standby power systems shall comply with 9.1.3.1 and 9.1.3.2. 9.1.3.1 Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. **Actual NFPA Standard: NFPA 110, Standard for Emergency and Standby Power Systems (2010)** 8.3.7.1 Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted.