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 – Oxford

Location: 120 Veterans Blvd., Oxford, MS 38655

Onsite / Virtual: Onsite

Dates of Survey: 8/27/24 – 8/30/24

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 125

Census on First Day of Survey: 121

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from August 27,2024, through August 30, 2024, at the Mississippi State Veterans Home – Oxford. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.70 (n) Self-Administration of Drugs. An individual resident may self-administer drugs if the interdisciplinary team, as defines by § 51.110(d)(2)(ii) of this part, has determined that this practice is safe. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected –** Few	Based on observation, interview, and record review, the facility failed to ensure that for residents who may self-administer drug that it was first determined that this practice was safe for one (1) of one (1) resident reviewed for self-administering medication (Resident #1). The findings include: Review of the facility policy titled, "Medication Administration," dated 2/12/13, found documented: "10. Patients are not allowed to self- administer medications unless specifically authorized to do so by their Physician or in a section of the facility deemed suitable by this facility and then only in accordance with the procedures for bed-side medication…14. In order to assure accuracy in the administration of medications. The nurse administering the medication is responsible for checking to see that the drug and dosage schedule on the patient's medications administration record matches the label on the drugs container. If the drug container is marked with a single-type label indicating a recent change in directions for use, or there is any reason to

	question the dosage or the dosage interval, the nurse is to check the Physicians orders for the correct dosage schedule." Observation of Licensed Nurse A revealed that they administered Resident #1 MiraLAX (laxative) in a cup at 10:58 a.m. Licensed Nurse A observed Resident #1 take two sips of the medication, then walked away towards the medication cart. Resident #1 did not completely take the full dose of MiraLAX until 11:02 a.m. Resident #1 appeared to have difficulty swallowing the medication. Review of Resident #1's Face Sheet documented an admission date of [DATE], and revealed the resident's medical diagnoses included: Parkinson's Disease, Hypertension, Dysuria, Abnormal Weight loss, Hypomagnesemia, Gastro Esophageal Reflux Disease, Hyperlipidemia, and Chronic Kidney Disease. Review of Resident #1's Physician Orders documented that Resident #1 was not ordered to self-administer medications. The order read: "MiraLax powder (1 capful) oral every day for constipation in a 6 - 8-ounce cup of water or juice." Review of Resident #1's Nutrition assessment, dated [DATE], revealed: "Unintended weight loss and mechanically altered diet (pureed). Resident #1 refuses peg tube but continues to aspirate with pureed diet." Review of Resident #1's quarterly Minimum Data Set, dated [DATE], revealed for Section C, Cognitive Pattern, a Brief Mental Status score of 14, which meant the resident was cognitively intact for interview. During an interview with Licensed Nurse A, on 8/27/24, at 11:10 a.m., they stated they thought Resident #1 finished their medication. Licensed Nurse A stated the protocol was for staff to wait until residents completed their medication(s) before walking away. Licensed Nurse A stated that Resident #1 could have choked. During an interview with Administrative Nurse A, on 8/27/24, at 12:19 p.m., Administrative Nurse A stated that it was not protocol for staff to leave a resident while administering medication(s). Administrative Nurse A further stated that Licensed Nurse A should have made sure Resident #1 completed their medication before walking off.
§ 51.140 (c) Menus and nutritional adequacy. Menus must— (1) Meet the nutritional needs of	Based on observations, menu review, staff interviews, and facility policy review, the facility failed to ensure the nutritional adequacy of the menus for residents who received pureed diets. Specifically, the facility did not add bread to the pureed diets as

residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; (2) Be prepared in advance; and (3) Be followed. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	was listed on the menus. This failed practice affected six (6) out of six (6) residents who received pureed diets. The findings include: Review of the facility's undated policy titled, "Inservice for Modified Diets," documented: "A modified diet is a meal plan that controls the intake of certain foods or nutrients as part of treatment of a medical condition. The planning of each modified diet is based on the regular diet. The RWB Hospitality Dietary Department is responsible for the delivery of all diets correctly per the recipe and production sheets. Our mission is to provide nutritious, attractive, and palatable meals as stated in the Federal regulations and to help provide the highest quality of life for each resident." Observations of the pureed foods being served on 8/28/24, at 12:15 a.m., revealed the residents, who received pureed diets, received a vegetable, a potato, a meat, and a dessert for their lunch. Review of the posted menu, for 8/28/24, listed on the main menu: Fried Chicken, Turnip Greens, Macaroni and Cheese, Cornbread, and Sweet Potato Pie for dessert. Review of the "Production Counts" sheets, which documented what each diet type was to receive, found specified that the residents who had pureed diets were to receive a pureed roll for lunch. On 8/28/24, at 12:20 a.m., in an interview with Dietary Staff A, they stated that they give the residents who were on pureed diets one (1) meat and two (2) vegetables. They further stated that they don't give bread to the residents who received pureed diets. On 8/28/24, at 12:25 p.m., in an interview with Administrative Staff A, they stated that the pureed diets were to be served with bread, as was stated on the menu. They further stated that they would fix this situation and make sure they received bread as listed.
§ 51.140 (h) Sanitary conditions. The facility must: (1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; (2) Store, prepare, distribute, and serve food under sanitary conditions; and (3) Dispose of garbage and refuse properly.	Based on observation, interview, and facility policy review, the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety. 1) The facility failed to ensure the dishwashing machine was cleaning at the required temperature for one (1) of one (1) facility dishwasher; 2) The facility failed to ensure [LOCATION] staff wore proper hair garments (hairnets) to prevent contamination; and 3) The facility failed to ensure proper hand hygiene practices were adhered to prevent the spread of infection. The sanitary concerns observed in the

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	[LOCATION] had the potential to affect all 121 residents who received meals from the [LOCATION]. The findings include: 1. During the initial tour of the [LOCATION], on 8/27/24, at 10:30 a.m., during the initial [LOCATION] tour, The dish machine showed a temperature of 120 degrees Fahrenheit (F) for the wash cycle, and 170 degrees F for the final rinse. Review of the August 2024 "Dishwasher Temperature Chart" document revealed that the final rinse temperatures had been registering at 170 degrees Fahrenheit consistently from 8/9/24, through 8/27/24. Further review of the temperature log revealed: "Check rinse temperature every meal. Record temps every morning. If the temp is under 160 degrees after three consecutive racks have gone through the rinse, report it immediately to the chef or property manager. Racks that go through at less than 160 degrees must be run through again until they've been rinsed by 160 degree or hotter water." The dates and temperatures listed were: 8/9/24, was documented at 170 degrees Fahrenheit for Breakfast; 8/10/24, was documented at 170 degrees Fahrenheit for lunch and dinner; 8/11/24, was documented at 170 degrees for lunch and dinner; 8/12/24, was documented at 170 degrees Fahrenheit for lunch and dinner; 8/13/24, was documented at 170 degrees Fahrenheit for lunch and dinner; 8/14/24 was documented at 170 degrees Fahrenheit for breakfast, 181 degrees Fahrenheit for lunch and dinner; 8/15/24, was documented at 170 degrees Fahrenheit for breakfast and lunch; 8/16/24, was documented at 170 degrees Fahrenheit for all three meals; 8/17/24, was documented at 170 degrees Fahrenheit for all three meals; 8/18/24, was documented at 170 degrees Fahrenheit for all three meals; 8/19/24, was documented at 170 degrees Fahrenheit for all three meals; 8/20/24, was documented at 170 degrees Fahrenheit all three meals; 8/21/24, was documented at 170 degrees Fahrenheit for all three meals; 8/22/24, was documented at 170 degrees Fahrenheit for all three meals; 8/23/24, was documented at 170 degrees Fahrenheit for all three meals; 8/24/24, was documented at 170 degrees Fahrenheit for all three meals; 8/25/24, was documented at 170 degrees Fahrenheit for all three meals; 8/26/24, was documented at 170 degrees Fahrenheit all three meals; 8/27/24, was documented at 170 degrees Fahrenheit all three meals. None of the listed temperatures matched the proper sanitizing temperatures for a low or high temperature dish machine. During an interview with Dietary Staff A, at 10:45 a.m., they stated that the service provider for the dish machine was supposed to come in last week, but they didn't show up. They

	stated they thought the dish machine might be a low temp machine, but they weren't sure. They stated that they were going to call their service provider again. Dietary Staff A further stated that two weeks ago, they sanitized the dishes by hand due to the dish machine having the wrong temperatures, but they haven't done that for the last two weeks. They stated that they thought the dish machine was fixed since their service provider came into the facility two weeks ago. They then stated that the staff would hand sanitize the dishes again until their service provider could come back and fix the machine. On 8/27/24, at 11:00 a.m., in an interview with Administrative Staff B, they stated that they would look into the issue. They further stated that last month they purchased a new booster heater for the dish machine, and they thought the machine was fixed. A review of the dish machine's manufacturer's guidelines revealed the dish machine was, in fact, a low temperature dish machine, and the wash and the rinse cycles were to run at 120 degrees Fahrenheit. On 8/28/24, at 2:00 p.m., in a follow up interview with Administrative Staff B, they stated that the dish machine would be "fixed by the end of the day." They stated that they had bought a new booster heater because the temperature was not reaching the required 140 degrees Fahrenheit. They also stated that their service provider told them the dish machine was a low temperature dish machine, and when the rinse temperature ran over 140 degrees Fahrenheit, the sanitizer would be destroyed. On 8/28/24, at 2:10 p.m., Maintenance Staff A stated that their service provider was coming in to fix the machine and conduct an in-service review with the staff on proper use of the dish machine. 2. During the initial noon meal observation of the [LOCATION] on 8/27/224, at 12:27 p.m., Dietary Staff B was observed in the tray preparation area with a baseball cap on their head with their hair not contained under the cap. Dietary Staff B's hair was hanging down around their shoulders and neck area, and they had no gloves on. Open cups of pudding and fruit were observed on the tray line that Dietary Staff B was standing around. When Dietary Staff B was asked about a hairnet, they stated they thought a baseball cap was ok.

	On 8/27/24, at 12:35 p.m., in an interview with Dietary Staff A, they stated they thought the staff had the option of either a hairnet or baseball cap. On 8/27/24, at 3:40 p.m., during an interview with Dietary Staff B, the surveyor asked what should be worn during tray preparation. Dietary Staff B replied, "Hairnet and gloves." The surveyor asked what they wore during lunch tray preparation on 8/27/24, during the lunch preparation today, and Dietary Staff B replied, "A baseball cap and no gloves." The surveyor asked when hairnets and gloves were not worn during tray preparation, what was the potential for harm to residents' who received meals from the [LOCATION]? Dietary Staff B replied, "hair in the food." Review of an undated policy titled, "RWB Hospitality Policy on Hair and Beard Nets," noted: "d. Hairnets must be always worn." A sign was posted on the [LOCATION] door, "Hairnets must be worn." 3. During the noon meal service, on 8/28/24, at 11:45 a.m., a member of the dietary staff was assisting with serving the noon meal on the tray line. They were observed changing gloves approximately four times during the service. However, they did not wash their hands between donning and doffing gloves. On 8/28/24, at 12:00 p.m., in an interview with Dietary Staff A, they stated that the staff were to wash their hands prior to the start of the noon meal and following the noon meal, but not between glove changes. On 8/28/24, at 2:00 p.m., in an interview with Dietary Staff C, they acknowledged that hands needed to be washed between changing gloves. Review of the facility policy, undated, found: "RWB Hospitality Gloves Employees are to wear gloves at all times when handling ANY food items. Remember you must CHANGE GLOVES as needed and you must WASH YOUR HANDS!"
§ 51.190 (b) Preventing spread of infection. (1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility management must isolate the resident. (2) The facility management must	Based on observation, interview, and record review, and the facility's policy review, the facility failed to ensure nursing staff washed their hands after removing gloves. This affected one (1) of one (1) wound care observations (Resident #3) and had the potential to affect two (2) residents receiving wound care. The findings include:

prohibit employees with a communicable disease or infected skin lesions from engaging in any contact with residents or their environment that would transmit the disease. (3) The facility management must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	A review of the facility's policy and procedure titled, "UNIVERSAL PRECAUTIONS," with a review date of March 18, 2022, revealed the following: "PROCEDURE: A. Handwashing…2. Wash hands immediately gloves are removed…and when otherwise indicated to avoid transfer of microorganisms to other residents or environments." A review of the facility's policy and procedure titled, "PERSONAL PROTECTIVE EQUIPMENT," dated 8/9/23, revealed the following: "PROCEDURE: …v. Hand washing is necessary when gloves are removed." On 8/28/24, at 10:00 a.m., during wound care set up for Resident#3, Licensed Nurse B was observed. They applied gloves and removed a container of Sani-Wipes from the treatment cart and cleaned the cart. Then Licensed Nurse B removed their gloves and did not wash their hands or use hand sanitizer. Licensed Nurse B proceeded to remove supplies from the treatment cart, and placed the supplies on a tray, which was laid on top of the treatment cart, for wound care. Licensed Nurse B did not wash their hands or use any hand sanitizer. Licensed Nurse B then opened the Q-tips, removed a tube of cream, and dispensed the cream into two (2) small cups. Licensed Nurse B applied gloves and used Sani wipes to wipe the container of wound cleanser and the tube of cream. Then Licensed Nurse B removed their gloves, but did not wash their hands or use any hand sanitizer. Licensed Nurse B then removed additional supplies from the treatment cart in preparation for wound care. On 8/28/24, at 10:28 p.m., during an interview with Licensed Nurse B, the surveyor asked what should be done when gloves were removed. Licensed Nurse B replied, "Wash hands." The surveyor asked was that what they had done when they removed their gloves. Licensed Nurse B replied, "I didn't. Sorry."