STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255325	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wisteria Gardens	5420 Highway 80 East Pearl, MS 39208

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50921 Based on facility policy review, record reviews, and staff interviews, the facility failed to correctly code a Minimum Data Set (MDS) discharge assessment for one (1) of fourteen (14) sampled residents reviewed for assessment accuracy. Resident #48 Findings Include: Record review of the facility's, Accurate Completion of Social Determinates of Health -Minimum Data Set (MDS) Policy dated October 2023 revealed It is the policy of this facility to ensure that . data are accurately captured within the MDS per the current Resident Assessment Instrument (RAI) Guidelines .The MDS Coordinator will ensure that these data elements are carried out timely and coded accurately . Record review of the Discharge Minimum Data Set (MDS) for Resident #48 revealed an admitted [DATE]. Record review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/10/24 in Section A revealed Resident #48 was discharged to an acute hospital. Record review of the facility's, Progress Notes revealed Resident #48 was discharged home with Hospice on 12/10/2024. During an interview with the Registered Nurse (RN) #2, MDS Coordinator on 2/19/25 at 2:00 PM, confirmed he failed to accurately code Resident #48's Discharge MDS assessment dated [DATE]. During an interview with the Director of Nursing (DON) on 02/20/2025 at 8:55 AM confirmed the facility failed to code the discharge MDS correctly. MDS discrepancy is a result in error of interpretation of notes. Progress notes states that resident was released to Baptist Hospice- Note was interpreted as resident was released to Hospital. DON stated that correction has been submitted and DON expectations of the MDS Coordinator is to code correctly per regulation guidelines. During an interview on 2/20/25 at 10:05 AM with the Administrator, stated she was informed of the MDS inaccurate coding for discharge for resident #48.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 41680 Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure the medication error rate was less than five percent (5%) as evidenced by three (3) errors were observed out of 29 medication administration opportunities. This affected two (2) of four (4) residents observed during medication pass, resulting in a medication error rate of 10.34%. (Resident #43 and Resident #154) Findings Include: A record review of facility's policy Medication and Treatment Orders, undated, revealed, .Orders for medications and treatments will be consistent with principles of safe and effective order writing . Resident #43 A record review of the Admission Record revealed the facility admitted Resident #43 on 01/20/2025 with current diagnoses including Chronic Obstructive Pulmonary Disease (COPD). A record review of the Order Summary Report, with Active Orders As Of: 2/19/25, revealed Resident #43 ' s had a Physician ' s Order, dated 2/13/25 for Breo Ellipta Inhalation Powder Breath Activated, one (1) puff one puff inhaled orally once daily for COPD . On 2/19/25 at 9:40 AM, during observation, Licensed Practical Nurse (LPN) #3 was unable to locate Breo Ellipta inhaler in the medication cart for Resident #43. LPN #3 went into the resident's room and asked if the medication was in her room and Resident #43 stated that she did not know where it was. The medication was not administered. On 02/19/2025 at 11:08 AM, during an interview, LPN #3 stated she had not been able to locate the Breo Ellipta to administer to Resident #43. On 02/19/2025 at 2:14 PM, during an interview, LPN #3 confirmed that she had not given Resident #43 the Breo Ellipta because she could not locate it. On 02/19/2025 at 2:33 PM, during an interview, the Director of Nursing (DON) stated that failing to administer the Breo Ellipta as prescribed could cause Resident #43 to experience shortness of breath (SOB) and lightheadedness. The DON stated she expected nurses to administer medication as prescribed and to order a replacement if a medication could not be located. A review of Resident #43's February 2025 Electronic Medication Administration Record (EMAR) revealed the Breo Ellipta was not administered on 02/19/2025. Resident #154 A record review of the Admission Record revealed the facility admitted Resident #154 on 02/13/2025 with current diagnoses including Unspecified Glaucoma. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the Order Summary Report with active orders as of 2/19/25, revealed Resident #154 had a physician's order, dated 2/13/25, for Timolol Maleate Ophthalmic Solution 0.5%, instill one (1) drop in both eyes two times daily. On 2/19/25 at 9:20 AM, during an observation, LPN #3 administered Timolol Maleate Ophthalmic Solution two (2) drops in each eye for Resident #154. On 02/19/2025 at 9:29 AM, during an interview, LPN #3 confirmed that she administered (2) drops in each eye for Resident #154 and stated she should have administered (1) drop in each eye as per physician orders. On 02/19/2025 at 2:28 PM, during an interview, the DON stated that LPN #3 should have administered only (1) drop per eye according to the physician's order. The DON stated she expected staff to follow physician orders accurately during medication administration.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41680 Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure medications were safely and securely stored for one (1) of four (4) residents observed for medication administration. Resident #43 Findings Include: A record review of the facility's Medication Labeling and Storage revised 2/2023, revealed, .The facility stores all medication and biologicals in locked compartments .Medication Storage .2. The nursing staff is responsible for maintaining medications storage and preparation areas in a clean, safe, and sanitary manner . On 02/19/2025 at 9:45 AM, during an observation with Licensed Practical Nurse (LPN) #3, Albuterol Sulfate HFA Inhalation Aerosol Solution was observed on Resident #43's nightstand table in a clear plastic bag. On 02/19/2025 at 2:14 PM, during an interview, LPN #3 stated that no medications should be left at the bedside unless there is a physician's order permitting it. She explained that leaving medications at the bedside could result in the resident overdosing on the medication, which could cause damage to the lungs if overdosed. She confirmed that the Albuterol inhaler should not have been left on the nightstand. On 02/19/2025 at 2:33 PM, during an interview, the Director of Nursing (DON) stated that no medications should be left at the bedside unless ordered by a physician. She explained that if medications are left at the bedside, residents could use more than prescribed, leading to overuse. The DON stated that overuse of Albuterol could cause Resident #43 to experience shortness of breath (SOB) and lightheadedness. She confirmed that it was her expectation that nursing staff would ensure medications are securely stored according to facility policy. A record review of the Admission Record revealed the facility admitted Resident #43 on 01/20/2025 with current diagnoses including Chronic obstructive pulmonary disease (COPD). A record review of the Order Summary Report with active orders as of 2/19/25, revealed Resident #43 had a physician order dated 1/20/25, for Albuterol Sulfate HFA Inhalation Aerosol Solution one (1) puff inhale orally every six hours as needed for Shortness of breath/wheezing related to COPD.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48181 Based on observation, staff interview, and facility policy review, the facility failed to store food and maintain sanitary practices in accordance with professional standards for food safety related to expired foods, freezer burned foods, improperly stored foods, and unlabeled and undated foods for two (2) of (2) kitchen observations. Findings include: A review of the facility's policy, Handling of Perishable Foods, Revision Date: [DATE] revealed, Policy: To ensure foods are protected from contamination or spoilage. Any growth of organisms is prevented by proper storage and temperatures .Policy .10. All items .will be properly labeled with the Item, Initials, Date and use by date .12. Any food items not properly stored will be disposed of immediately . On [DATE] at 10:15 AM, during an observation of the kitchen and an interview with the Certified Dietary Manager (CDM), the walk-in refrigerator was observed to contain a one (1) gallon bottle of lime juice with a manufacturer's date of [DATE] on the lid and a white cloudy film at the bottom of the bottle. There were (2) unopened containers of beef tips with no date or identifying label and (1) opened package of diced ham with no label. An unopened package of roast beef slices was observed with manufacturer's instructions to use or freeze by [DATE], but it did not have a facility thawed on or use by date. Additionally, there was an unopened bag of chopped cabbage labeled Best if used by [DATE]. In the freezer, (2) opened and three (3) unopened bags of chicken gizzards were observed without identifying labels and had white discoloration consistent with freezer burn. The CDM acknowledged the outdated, unlabeled, and inappropriately stored food items and explained that it is the responsibility of all kitchen staff to check for and discard expired foods, as well as to label and date food items. The CDM stated that food items should have been labeled and dated according to facility practices. She explained that she conducts food safety training in-services for the kitchen staff twice a year and stated that labels are available to identify the date of opening, thawed on, and use by dates. The CDM stated that she would review the labeling procedures with the kitchen staff. On [DATE] at 9:17 AM, during an interview, the [NAME] stated that all kitchen staff are responsible for labeling and dating food items and ensuring expired foods are discarded. The [NAME] explained that once a food item is opened, staff have three (3) days to use it or discard it. The [NAME] emphasized that everyone in the kitchen is responsible for labeling, dating, and monitoring for expired foods. The [NAME] also stated that staff receive in-service training on food safety every six (6) weeks. On [DATE] at 9:20 AM, during an interview, the Dietary Aide (DA) stated that the staff member assigned to put away items from the delivery truck is responsible for labeling them. The DA explained that all kitchen staff are responsible for monitoring food items and discarding expired foods. The DA also stated that staff receive in-service training on food safety once a month. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 10:05 AM, an interview with the Administrator, she acknowledged the outdated, unlabeled, and inappropriately stored items in the kitchen. The Administrator stated and the owner of the facility currently has a practice of conducting spot checks in the kitchen every two (2) weeks. The Administrator stated she will increase her presence in the kitchen to assist with making sure the food is monitored appropriately. The Administrator stated that her expectation for the kitchen staff is that they will do it right by monitoring for outdated, undated and unlabeled foods.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50751 Based on record review, staff interview, and facility policy review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to sustain corrective actions to prevent recurrence of a previously cited deficiency. Specifically, the facility was cited for failing to label, date, and discard expired items stored in the refrigerator, freezer, and dry storage room during an annual recertification survey on [DATE] and was cited again for the same deficiency during the current survey, demonstrating that QAPI failed to sustain ongoing monitoring and oversight to prevent recurrence for one (1) of six (6) deficiencies cited. F812 Findings Include: Review of the facility's policy Quality Assessment and Performance Improvement (QAPI) Program, undated, revealed .The facility shall .maintain a Quality Assurance and Performance Improvement (QAPI) Committee that oversees the implementation of the QAPI Program .Committee Audit Process .2. The QAPI Committee shall help various departments .develop and implement plans of correction and monitoring approaches .3. The committee shall track the progress of any active plans of corrections. 4. The committee shall advise the administration of the need for policy or procedural changes and, as appropriate, monitor to ensure that such changes are implemented . Record review of the Centers for Medicare and Medicaid Services (CMS-2567) (a record that identifies the federal regulation in violation and describes the findings of noncompliance and the facility's plan of correction), with a survey date of [DATE], revealed the facility received a citation for F812, .Based on observation, staff interviews, and facility policy review, the facility failed to ensure items in the kitchen refrigerator, freezers, and the dry storage room were dated, labeled, and discarded by the expiration date . During the current annual recertification survey, the facility failed to store food and maintain sanitary practices in accordance with professional standards for food safety related to expired foods, freezer burned foods, improperly stored foods, and unlabeled and undated foods for two (2) of (2) kitchen observations. On [DATE] at 11:45 AM, during an interview the Administrator, stated that she was aware that on the last annual survey on [DATE], the facility was cited for food procurement and unlabeled food items. She stated that she performed random checks of the kitchen for dates and labels several times a month along with the facility owner.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50751 Based on observations, interviews, and record and facility policy review, the facility failed to follow infection prevention guidelines in two (2) of (10) observed care procedures as evidenced by staff did not don (put on) appropriate personal protective equipment (PPE), including gowns, per Enhanced Barrier Precautions (EBP) during Percutaneous Endoscopic Gastrostomy (PEG) tube and Foley catheter care for Resident #43 and Resident #251. Findings Include: A record review of the facility's policy Enhanced Barrier Precautions dated April 2024 revealed .Policy Interpretation and Implementation: 1. EBP will be used in conjunction with standard precautions and expand the use of Personal Protective Equipment (PPE) to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of Multidrug resistant organism (MDROs) to staff . Resident #43 On February 19, 2025, at 1:42 PM, Licensed Practical Nurse (LPN) 1 was observed providing care to Resident #43's PEG tube site. LPN #1 did not don a gown before initiating the procedure and completed the entire care process without wearing a gown. During an interview at 1:42 PM, LPN #1 confirmed that EBP signage was posted on Resident #43's door. She acknowledged that the signage indicated that a gown and gloves should be worn when providing care. She further stated that she should have donned a gown before entering the resident's room to perform care, as the resident had a PEG tube that required site care, and failure to wear PPE could contribute to infection transmission. A review of the Admission Record revealed Resident #43 was admitted to the facility on [DATE] with diagnoses that included Cerebral infarction due to unspecified occlusion or stenosis of the right middle cerebral artery. A record review of Resident #43's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/27/25 revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating severely impaired cognition. A record review of Resident #43's Order Summary Report with active orders as of 2/29/25 revealed an order dated 1/21/2025 Clean PEG tube site with normal saline. Pat dry. Cover with gauze, and secure with tape daily on every day shift. Resident #251 On February 19, 2025, at 1:55 PM, Certified Nurse Aide (CNA) 1 was observed providing Foley catheter care for Resident #251. CNA #1 did not apply a gown before starting the procedure and completed the catheter care without wearing a gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on February 19, 2025, at 2:10 PM, CNA #1 confirmed that she did not wear a gown during the procedure but stated that she should have worn one, as the resident was on EBP. She acknowledged that a sign on the resident's door indicated that the resident had a Foley catheter, requiring staff to wear gowns to prevent infection transmission. A review of Resident #251's Admission Record revealed the resident was admitted on [DATE], with diagnoses that included Chronic kidney disease, Stage 3B. A review of Resident #251's MDS revealed the resident had a BIMS score of 3, indicating severely impaired cognition. A record review of Resident #251's Order Summary Report with active orders as 2/19/25 revealed a physician order dated 2/18/2025 8 (eight) ounces of water every 8 hours for hydration. An additional order dated 2/7/2025 revealed Monitor output of cath (catheter) every shift. During an interview on February 19, 2025, at 2:44 PM, the Infection Preventionist (IP) nurse stated that EBP requires staff to wear gowns and gloves when providing hands-on care to residents with invasive lines and tubes, such as PEG tubes or Foley catheters. She emphasized that gowns prevent the spread of MDROs and staff are expected to comply with PPE requirements per facility policy. During an interview on February 19, 2025, at 3:49 PM, the Director of Nursing (DON) stated that EBP requires gowns to be worn when caring for residents with MDROs, chronic wounds, Foley catheters, or PEG tubes, as these conditions place residents at increased risk for infection. The DON further stated that staff have been in-serviced on infection control protocols and are expected to follow Centers for Disease Control and Prevention (CDC) guidelines and facility policy to prevent the spread of infection.