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 _____	10/19/2023

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 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 10/16/2023 through 10/19/2023. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F697, F732, and F812. The facility had a census of 49 and was licensed for 60 beds	F 000		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record reviews, and facility policy review the facility failed to manage a resident's pain by not administering medication per physician orders for one (1) of three (3) residents reviewed for pain. Resident # 6 Findings include: A review of the facility policy, "Pain Assessment Management", with a revision date of 9/2023, revealed, "Purpose: The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs that address the underlying causes of pain ... The	F 697	1) Resident #6 was assessed for pain immediately and appropriate interventions were implemented. The doctor was notified and an order was obtained to change the prescription in order to meet the resident's needs. The interdisciplinary team reviewed the Minimum Data Set section J on 10/20/2023. Any resident that triggered a positive response was evaluated to ensure their pain was managed to an acceptable level. 2) All residents have the potential to be affected by this deficient practice. 3) All licensed nursing staff will be	11/30/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/06/2023

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F 697	Continued From page 1 medication regimen is implemented as ordered. Results of the interventions are documented and communicated directly to the provider when appropriate ..." On 10/16/23 at 10:32 AM, in an interview with Resident #6, she revealed she has back and leg pain. She stated her pain is controlled by a pain patch on her back, but the nurse had told her that the facility is out of the patch. On 10/17/23 at 11:09 AM, during an interview with Resident #6, she commented that the facility was still out of her pain patch. On a scale of one to ten (1-10), the resident rated her pain level as "8". The resident explained the pain patch "helps with her back pain" and that she "really needed it." She stated when they put the patch on, she has very little back pain. Resident #6 revealed her pain level is never completely gone, but the patch decreases it to a "1 or 2." The resident was unable to remember the last time that a pain patch had been applied but stated that she thinks "it was either Thursday or Friday of last week." The resident further explained that the nurse had told her that it had been ordered from the pharmacy, and she will be glad when it comes in, as she needs the patch. On 10/17/23 at 11:25 AM, in an interview with Licensed Practical Nurse #1 (LPN), she stated the Lidocaine patches came in today and were in the medication room. The nurse revealed she had not yet applied a pain patch; however, the resident told her she was not in pain. On 10/17/23 at 11:30 AM, an observation of the medication room with LPN #1, revealed the Lidocaine patches were not in stock in the	F 697	in-serviced on the facility's pain management policy and procedure by 11/10/2023. This in-service was led by the Director of Nursing and the Corporate Nurse. 4) The Director of Nursing will complete pain assessment audits weekly x 6 weeks to ensure appropriate completion. Weekly audits will begin on 11/6/2023. Audits will be reviewed weekly by the Quality Assurance Committee, made up of the Medical Director, Administrator, Director of Nursing, and Corporate Nurse, until such time consistent substantial compliance has been achieved as determined by the committee. Weekly QA reviews will take place every Wednesday, beginning on 11/8/2023, in order to review results of each weekly audit. The QA Committee will meet on 11/30/2023 to review all findings of the audits. Audit results will be shared with Resident/Family Council for comment and suggestion. The meeting will take place on 11/30/2023.	

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F 697	Continued From page 2	F 697		

medication room.

On 10/17/23 at 11:32 AM, in an interview with the Director of Nursing (DON, she) stated there is a button in the Electronic Medication Administration Record (EMAR), that allows the nurses to reorder medications. The DON revealed the reorder of medications usually takes about a week, but sometimes the order does not come in and they have to contact the pharmacy.

On 10/17/23 at 2:30 PM, in an interview with LPN #1, she stated she had not talked with the DON about Resident #6's lidocaine patches but will do so prior to leaving today. LPN #1 once again stated Resident #6 continued to rate her pain level at a zero (0).

On 10/18/23 11:03 AM, in an interview with LPN #2, he revealed Resident #6 had an order for a 5% (five percent) Lidocaine patch. LPN #2 stated they had been out of the patch for several days, as the patch was on back order. However, he revealed they now have a new order for Resident #6 to receive a 4% (four percent) Lidocaine patch.

On 10/18/23 11:10 AM, in an interview with the Director of Nursing (DON), she stated she did not know the resident was out of Lidocaine patches until yesterday. She revealed she had contacted the pharmacy and was told it is on back order, so she had contacted the physician and received an order to change the Lidocaine patch from 5% to 4%. The DON confirmed that the nurse should have called the pharmacy to follow-up on the Lidocaine patches and when she found out that they were not available, she should have contacted the physician, as the physician would

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F 697	Continued From page 3	F 697		

have changed the order earlier to meet the needs of the resident.

On 10/18/23 at 3:04 PM, in an interview with Resident #6, she stated they put her patch back on today and her pain level had decreased to a level 2.

A record review of "Face Sheet" for Resident # 6 revealed the facility admitted the resident to the facility on 9/21/23, with diagnoses that included Periprosthetic fracture Around Internal Prosthetic Right Knee Joint, Spinal Stenosis, Spondylosis Without Myelopathy or Radiculopathy of Cervical Region, and Radiculopathy of Lumbar Region.

Record review of the October 2023 Physician Orders for October 2023 revealed an order dated 9/28/23 "Lidocaine 5% Patch Apply 1 patch topically daily to lower back (on for 12 hours and off for 12 hours)."

Review of the Admission Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 9/28/23, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.

A record review of the pharmacy invoices for September and October 2023 revealed the facility received a 14-day supply of Lidocaine 5% patches on 9/28/23 for Resident #6. The facility had not received additional Lidocaine 5% patches for Resident #6 since 9/28/23. The start date was 9/29/23, which indicates Resident #6 was out of the Lidocaine patches for five days.

On 10/19/23 1:17 PM, in an interview with Resident #6 stated that they put her pain patch on

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F 697	Continued From page 4 this morning. She denied being in any pain.	F 697		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of	F 732		11/30/23

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F 732	Continued From page 5 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to post the daily staffing hours for public viewing (4) of four (4) days reviewed for staff posting. Findings include: Record review of the facility's policy, "Posting Direct Care Daily Staffing Numbers," undated, revealed "...Our facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. Policy Interpretation and Implementation 1. Within two (2) hours of the beginning of each shift, the number of Licensed Nurses (RNs, LPNs, and LVNs) (Registered Nurses, Licensed, Practical Nurses, and Licensed Vocational Nurses) and the number of unlicensed nursing personnel (CNAs) (Certified Nurse Aides) directly responsible for resident care will be posted in a prominent location (accessible to, residents and visitors) ...5. Within two (2) hours of the beginning of the shift, the shift supervisor shall compute the number of direct care staff and complete the Nursing Staff Directly Responsible for Resident Care form ... and post the staffing information in the location(s) designated by the Administrator ...9. Staffing information during the recorded time period shall be made available to residents, family members, and the public ..." On 10/16/2023 at 10:23 AM, an observation of the staffing board opposite the nurses' station revealed only the date, nurses' hall assignments, and CNA hall assignments. Daily staffing hours	F 732	1) The Director of Nursing was in-serviced by the Corporate Nurse on 10/19/2023 on the appropriate posting requirements on staffing. 2) All residents have the potential to be affected by this deficient practice. 3) The facility posted the required information immediately in a clear and readable format that is readily accessible to residents and visitors. The Director of Nursing in-serviced the Assistant Director of Nursing and the Lead Certified Nursing Assistant on the posting of the nursing staff information on 10/20/2023. The other nursing staff will be in-serviced on the posting requirements by 11/10/2023. 4) The Assistant Administrator will complete an audit one time a week x 6 weeks to ensure the appropriate information is posted. Weekly audits will begin on 11/1/2023. Audits will be reviewed weekly by the QA committee, made up of the Medical Director, Administrator, Director of Nursing, and Corporate Nurse, until such time consistent substantial compliance has been achieved as determined by the committee. Weekly QA reviews will take place every Wednesday, beginning on 11/8/2023, in order to review results of each weekly audit. The QA Committee will meet on 11/30/2023 to review all	

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F 732	Continued From page 6 were not posted anywhere in the facility. On 10/17/2023 at 12:20 PM, an observation of the staffing board opposite the nurses' station revealed only the date, nurses' hall assignments, and CNA hall assignments. Daily staffing hours were not posted anywhere in the facility. On 10/17/23 at 12:23 PM, during an interview with the Director of Nursing (DON), she verified that shift-specific work hours are not included on the staffing board. She did mention that she records the hours worked on a "daily staffing sheet" that has been maintained in her office for several months. On 10/18/2023 at 9:17 AM, an observation of the staffing board opposite the nurses' station revealed only the date, nurses' hall assignments, and CNA hall assignments. Daily staffing hours were not posted anywhere in the facility. On 10/19/2023 at 11:57 AM, an observation of the staffing board opposite the nurses' station revealed only the date, nurses' hall assignments, and CNA hall assignments. Daily staffing hours were not posted anywhere in the facility. On 10/19/23 at 12:02 PM, in an interview with the Director of Nursing (DON) stated that visibly posting actual hours worked ensures that residents, staff, and visitors know that the facility is adequately staffed. On 10/19/23 at 12:16 PM, CNA Team Leader #1 stated in an interview that she was unaware of the facility posting the hours worked by licensed and unlicensed personnel in the building	F 732	findings of the audits.	

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F 732	Continued From page 7 On 10/19/2023 at 1:22 PM, in an interview with the Assistant Administrator, she confirmed that actual hours worked by licensed and unlicensed personnel should be posted daily for staff, visitors, and residents to see.	F 732		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility policy review, the facility failed to ensure items in the kitchen refrigerators, freezers, and the dry storage room were dated, labeled, and discarded by the expiration date for one (1) of three (3) dietary observations. This has the potential to affect all residents receiving meals prepared by the facility's dietary department.	F 812	1) The Dietary Manager was in-serviced on 10/16/2023, by the Administrator, on the proper way to store, label and discard food. The dietary staff immediately discarded expired, non-labeled and improperly stored food items. 2) All residents have the potential to be affected by this deficient practice.	11/30/23

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F 812	Continued From page 8 Findings include: Review of the facility's policy titled, "Food Storage (Dry, Refrigerated, and Frozen)" dated 2016, revealed, ... "Discard food that has passed the expiration date, and discard food that has been prepared in the facility after seven days of storing under proper refrigeration ..." An observation of the kitchen on 10/16/2023 at 9:15 AM, with the Dietary Manager (DM), revealed several expired food items. There were three (3) 46 ounce (oz). cartons of Lyons Ready Care cranberry cocktail, with a received date of 11/22/22, and an expiration date of 2/23. There were six (6) 24 oz bottles of Hershey's chocolate syrup, with an expiration date of 9/23. One of the Hershey chocolate syrup bottles had been opened, with approximately 1/3 of the syrup remaining in the bottle. The opened bottle was labeled with an open date of 5/27/22. There were three (3) 46 oz. cartons of Lyons orange juice, with an open date of 4/29/22, and an expiration date of 7/12/22. There was a one (1) gallon jug of Worcestershire Sauce, with an open date of 2/11/22, and an expiration date of 5/20/22. Additionally, there were eight (8) frozen pancakes wrapped in plastic wrap, without a name or date on it. During an interview with the DM on 10/16/23 at 9:50 AM, she revealed that in their facility, the DM is responsible for discarding expired foods. The DM confirmed that if residents were served expired foods, they could get sick. On 10/19/23 at 12:18 PM, in an interview with the Assistant Administrator, she confirmed that the expired foods should have been discarded, as	F 812	3) All dietary staff was in-serviced on the policy and procedures for proper food storage, labeling and disposal on 11/1/2023. 4) The Dietary Manager will conduct checks of the refrigerators, freezers and dry storage rooms weekly x 6 weeks. The first weekly check will be 10/30/2023. The Administrator will complete audits once a week x 6 weeks to ensure proper storage, labeling and disposal of food items and to ensure the weekly checks are being completed. The first weekly audit will be 11/1/2023. Audits will be reviewed weekly by the Quality Assurance Committee, made up of the Medical Director, Administrator, Director of Nursing, and Corporate Nurse, until such time consistent substantial compliance has been achieved as determined by the committee. Weekly QA reviews will take place every Wednesday, beginning on 11/8/2023, in order to review results of each weekly audit. The QA Committee will meet on 11/30/2023 to review all findings of the audits.	

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F 812	Continued From page 9 serving expired foods to residents could cause foodborne illnesses.	F 812		