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
	61WG	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

(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 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 02/18/2025 through 02/20/2025. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M815 and M1570.	M 000		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II 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: 09/2/2022 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 ..."	M 815	1. The Dietary Manager was in-serviced on February 18, 2025 by the Administrator on the proper way to label , date, store and discard food. The dietary staff immediately discarded non-labeled, improperly stored and expired food items. 2. All residents that partake in meals in the facility have the potential to be affected by this deficient practice. 3. All dietary staff was in-serviced by the Dietary Supervisor on the policy and procedure for proper food storage, labeling and disposal on March 5, 2025. 4. The Dietary Manager will complete checks of the refrigerators, freezers and dry storage room areas daily x 6 weeks. The first daily check was February 21, 2025. The Administrator will complete weekly checks of the refrigerators,	3/21/25

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/11/25

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M 815	Continued From page 1 On 02/18/2025 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 07/18/2024 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 12/01/2024," 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 02/13/2025." 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 02/20/2025 at 9:17 AM, during an interview, the Cook stated that all kitchen staff are responsible for labeling and dating food items and ensuring expired foods are discarded. The Cook explained that once a food item is opened, staff have three (3) days to use it or discard it. The Cook emphasized that everyone in the kitchen is	M 815	freezers and dry storage room areas every week x 6 weeks. The first weekly check was on February 23, 2025. The results of the first weekly check were reviewed by the Quality Assurance (QA) Committee on March 6, 2025. It was suggested for the Administrator and the Dietary Supervisor to review all policies and procedures pertaining to this deficiency. In addition, since this is a recurrence, it will be set up on a performance improvement plan and monitored through QAPI. A follow-up QA Committee meeting will be held March 20, 2025. Findings will continue to be reviewed by the QA Committee every 3 months.	

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M 815	Continued From page 2 responsible for labeling, dating, and monitoring for expired foods. The Cook also stated that staff receive in-service training on food safety every six (6) weeks. On 02/20/2025 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. On 02/20/25 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.	M 815		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases.	M1570		3/21/25

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M1570	Continued From page 3 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Level II 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	M1570	1. Licensed Practical Nurse (L.P.N.) 1 and Certified Nurses Assistant (C.N.A.) 1 were in-serviced by the Director of Nursing (D.O.N.) on February 19, 2025 on Enhanced Barrier Precautions (EBP) usage in conjunction with standard precautions during high contact resident care activities. 2. All residents that provide opportunities for transfer of Multi Drug Resistant Organisms (MDRO) to staff have the potential to be affected. 3. An in-service on the proper use of Personal Protective Equipment (PPE) usage in conjunction with EBP usage during high contact resident care activities was conducted on February 19, 2025 by the Consultant Nurse. This in-service was	

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M1570	Continued From page 4 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 1/20/25 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	M1570	for all nurses and all CNAs. 4. The Director of Nursing (D.O.N.) will observe residents requiring EBP usage beginning on March 5, 2025 for 3 residents a week x 4 weeks, then 2 residents 3 x week x 2 weeks. The results of the first audit were reviewed with the Quality Assurance (QA) Committee on March 6, 2025. No suggested changes in the policy and procedure were recommended at this time. A follow-up QA meeting to review findings will be held March 20, 2025. Findings will continue to be reviewed by the QA Committee every 3 months.	

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M1570	Continued From page 5	M1570		

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.

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 February 7, 2025, 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

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M1570	Continued From page 6 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.	M1570		