| 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 |

| (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) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>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 requirements of participation in Medicare and Medicaid and cited F641, F759, F761, F812, F865 and F880.<br><br>The facility had a census of 47 and was licensed for 52 beds. | F 000 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>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<br><br>Findings Include:<br><br>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 ....". | F 641 | 1. Resident #48 Minimum Date Set (MDS) was corrected immediately and transmitted with return validation.<br><br>2. All residents requiring a MDS have the potential to be affected by this deficient practice.<br><br>3. An in-service on the appropriate coding of section A was conducted by the Corporate Nurse on February 20, 2025. A 100% audit was initiated by the Director of Nursing (D.O.N.) on February 24, 2025 to ensure the accuracy of section A on the MDS.<br><br>4. The D.O.N. will audit 4 residents a week x 4 weeks, the 4 residents a week x 2 weeks to ensure accuracy of section A | 3/21/25 |

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

Electronically Signed | 03/11/2025

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.

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| F 641 | Continued From page 1<br>Record review of the Discharge Minimum Data Set (MDS) for Resident #48 revealed an admission date of 11/13/24.<br><br>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.<br><br>Record review of the facility's, "Progress Notes" revealed Resident #48 was discharged home with Hospice on 12/10/2024.<br><br>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 12/10/24.<br><br>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.<br><br>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. | F 641 | on the MDS. The results of the first audit from February 24, 2025 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 on March 20, 2025. Findings will continue to be reviewed by the QA Committee every 3 months. | |
| F 759 SS=E | Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) | F 759 | | 3/21/25 |

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| F 759 | Continued From page 2<br>§483.45(f) Medication Errors.<br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br>This REQUIREMENT is not met as evidenced by:<br>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)<br><br>Findings Include:<br><br>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..."<br><br>Resident #43<br><br>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).<br><br>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..." | F 759 | 1. The Facility Pharmacy was contacted on February 19, 2025 to obtain resident #43 Breo Ellipta Inhalation Powder. The medication was received later that same day. The Physician was notified of the missed does for resident #43 with no new orders obtained. The medication nurses were in-serviced on February 19, 2025 on the policy and procedure for ordering and receiving medications. The medication nurses were also in-serviced on the proper administration of Timolol Maleate Ophthalmic Solution eye drops February 19, 2025 for resident #154. The Physician was also notified of the administration of two eye drops for resident #154 instead of one as ordered with no new orders.<br><br>2. All residents that receive inhalers or eye drops have the potential for this deficient practice.<br><br>3. The Director of Nursing (D.O.N.) held an in-service on the policy and procedure of medication administration and ordering was held for all medication nurses on February 19, 2025.<br><br>4. The Pharmacy Nurse Consultant will monitor medication administration beginning March 11, 2025 for 1 x month x 2 months then quarterly thereafter. The | |

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| F 759 | Continued From page 3<br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>A review of Resident #43's February 2025 "Electronic Medication Administration Record (EMAR)" revealed the Breo Ellipta was not administered on 02/19/2025.<br><br>Resident #154<br><br>A record review of the "Admission Record" revealed the facility admitted Resident #154 on 02/13/2025 with current diagnoses including Unspecified Glaucoma. | F 759 | Registered Nurse (RN) Supervisor will monitor medication administration beginning February 24, 2025 4 x week x 2 weeks then 3 x week x 2 weeks then 2 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 to the policy and procedure were recommended at this time. A follow-up QA Committee meeting will be held on March 20, 2025. Findings will continue to be reviewed by the QA Committee every 3 months. Completion Date: April 21, 2025. | |

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| F 759 | Continued From page 4<br>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.<br><br>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.<br><br>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.<br><br>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. | F 759 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and | F 761 | | 3/21/25 |

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| F 761 | Continued From page 5<br>Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>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<br><br>Findings Include:<br><br>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..."<br><br>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.<br><br>On 02/19/2025 at 2:14 PM, during an interview, | F 761 | 1. Resident #43 Albuterol HFA Inhalation was removed from the residents bedside on February 19, 2025 and placed in a locked compartment per the policy and procedure. Licensed Practical Nurse (L.P.N.) #3 was in-serviced on proper medication storage February 19, 2025.<br><br>2. All residents that improperly store medications at bedside are at risk for this deficient practice.<br><br>3. The Director of Nursing (D.O.N.) held an in-service was held on proper storage of medications with all nurses on February 19, 2025.<br><br>4. The Pharmacy Nurse Consultant will monitor inhaled medications 1 x month x 2 months then quarterly thereafter. The Registered Nurse (RN) Supervisor will monitor medication administration beginning February 24, 2025 4 x week x 2 | |

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| F 761 | Continued From page 6<br>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.<br><br>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.<br><br>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).<br><br>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. | F 761 | weeks then 3 x week x 2 weeks then 2 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 to the policy and procedure were recommended at this time. A follow-up QA Committee meeting will be held on March 20, 2025. Findings will continue to be reviewed by the QA Committee every 3 months. | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements. | F 812 | | 3/21/25 |

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| F 812 | Continued From page 7<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>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.<br><br>Findings include:<br><br>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 ..." | F 812 | 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.<br><br>2. All residents that partake in meals in the facility have the potential to be affected by this deficient practice.<br><br>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.<br><br>4. The Dietary Manager will complete checks of the refrigerators, freezers and dry storage room areas daily x 6 weeks. | |

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| F 812 | Continued From page 8<br><br>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.<br><br>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 | F 812 | The first daily check was February 21, 2025. The Administrator will complete weekly checks of the refrigerators, 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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| F 812 | Continued From page 9<br>have three (3) days to use it or discard it. The Cook emphasized that everyone in the kitchen is 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.<br><br>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.<br><br>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. | F 812 | | |
| F 865 SS=D | QAPI Prgm/Plan, Disclosure/Good Faith Attmpt<br>CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i)<br><br>§483.75(a) Quality assurance and performance improvement (QAPI) program.<br>Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven | F 865 | | 3/21/25 |

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| F 865 | Continued From page 10 | F 865 | | |

QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must:

§483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;

§483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;

§483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and

§483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

§483.75(b) Program design and scope.
A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

§483.75(b)(1) Address all systems of care and

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| F 865 | Continued From page 11<br>management practices;<br><br>§483.75(b)(2) Include clinical care, quality of life, and resident choice;<br><br>§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.<br><br>§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.<br><br>§483.75(f) Governance and leadership.<br>The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:<br><br>§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.<br><br>§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;<br>§483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;<br><br>§483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. | F 865 | | |

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| F 865 | Continued From page 12<br><br>§483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and<br><br>§483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.<br><br>§483.75(h) Disclosure of information.<br>A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>§483.75(i) Sanctions.<br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br>This REQUIREMENT is not met as evidenced by:<br>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 10/19/23 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<br><br>Findings Include:<br><br>Review of the facility's policy "Quality Assessment and Performance Improvement (QAPI) Program," | F 865 | 1. The recurrence of tag F812-Food Procurement, Store/Prepare/Serve-Sanitary required actions from the Quality Assurance (QA) Committee on March 6, 2025. The QA Committee created a performance improvement plan for the way food is stored, labeled, dated and discarded.<br><br>2. All residents have the potential to be affected by this deficient practice.<br><br>3. The QA Committee determined that F812-Food Procurement, Store/Prepare/Serve-Sanitary should have been addressed through the Quality Assurance and Performance Improvement Plan (QAPI) after the last recertification survey in October of 2023. | |

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| F 865 | Continued From page 13<br>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..."<br><br>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 10/19/2023, 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 ..."<br><br>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.<br><br>On 2/20/25 at 11:45 AM, during an interview the Administrator, stated that she was aware that on the last annual survey on 10/19/23, the facility was cited for food procurement and unlabeled food items. She stated that she performed | F 865 | This review indicated a need for a performance improvement plan. An extensive review of all dietary policies and procedures pertaining to this deficiency have been reviewed by the Administrator and the Dietary Manager. They reported to the QA Committee on March 6, 2025. No changes in the policies needed to be made at this time. The dietary supervisor implemented a new labeling system. All dietary staff was in-serviced on the label system on February 24, 2025.<br><br>4. On March 6, 20255, the QA Committee appointed a Performace Improvement Plan (P.I.P.) team, consisting of the Administrator, Dietary Supervisor, one cook and one dietary aide. The PIP team met on March 7, 2025 and performed a root cause analysis and developed an improvement plan to correct the problem of tag F812. The PIP team began daily monitoring of the improvement plan on March 10, 2025. A follow-up QA meeting to review findings will be held on March 20, 2025. Findings will continue to be reviewed by the QA Committee every 3 months. | |

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| F 865 | Continued From page 14<br>random checks of the kitchen for dates and labels several times a month along with the facility owner. | F 865 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be | F 880 | | 3/21/25 |

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| F 880 | Continued From page 15<br>reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>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 | F 880 | 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 | |

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| F 880 | Continued From page 16<br>Enhanced Barrier Precautions (EBP) during Percutaneous Endoscopic Gastrostomy (PEG) tube and Foley catheter care for Resident #43 and Resident #251.<br><br>Findings Include:<br><br>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 ..."<br><br>Resident #43<br><br>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.<br><br>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.<br><br>A review of the "Admission Record" revealed Resident #43 was admitted to the facility on | F 880 | precautions during high contact resident care activities.<br><br>2. All residents that provide opportunities for transfer of Multi Drug Resistant Organisms (MDRO) to staff have the potential to be affected.<br><br>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 for all nurses and all CNAs.<br><br>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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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 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.

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| F 880 | Continued From page 18<br><br>A review of Resident #251's MDS revealed the resident had a BIMS score of 3, indicating severely impaired cognition.<br><br>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."<br><br>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.<br><br>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. | F 880 | | |