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 _____	C 09/10/2021

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
F 000	INITIAL COMMENTS An annual survey and Complaint Investigations (CI) MS#16634, CI MS#17888, and CI MS#17870 was conducted by the State Agency (SA) from 9/7/2021 through 9/10/2021. The facility was found to not be in compliance with the requirements of participation in Medicare and Medicaid. The SA substantiated the complaints for CI MS#16634, and CI MS#17870. related to abuse and visitation and cited F563, F609, and F610. The SA did not substantiate CI MS#17888 related to Resident/Patient Treatment with dignity and respect, Rehabilitation, Quality of care and treatment, and injury of unknown origin. The SA cited F636, F656, F690, F695 and F880 in the annual survey. The facility has a license for 52 with a census of 38.	F 000		
F 563 SS=E	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to	F 563		10/27/21

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

Electronically Signed | 10/20/2021

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F 563	Continued From page 1 the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident representative interview, record review, Resident Council Committee review and facility policy review the facility failed to honor the resident's rights for visitation with family for six (6) of 6 resident/resident representative interviews. Resident #138's Resident Representative and Resident #6, #8, #21, #87 and #140. Findings Include: Record review of the facility visitation policy titled, "Visitation during COVID-19 Public Health Emergency (PHE)", updated March 2021, revealed, wisteria gardens follows current guidelines and recommendations for the prevention and control of COVID-19. It is the goal of this facility to provide reasonable ways to facilitate in-person visitation to address the psychosocial needs of residents ...Indoor Visitation During an Outbreak ...1. When a new onset of COVID-19 among residents or staff is identified, the facility will immediately begin testing and suspend all visitation (except for compassionate care) until at least one round of facility-wide testing is completed. Visitation can	F 563	1) As of 9/9/2021, family and resident representatives for resident #6, #8, #21, #87, #138 and #140 were allowed visitation. 2) All residents residing in the facility have the potential to be affected by this deficient practice. 3) As of 9/9/2021, visitation for all residents is available per CMS/CDC guidance and policy and procedures. On 9/9/2021, signage was added to the facility entrance stating visitation availability per the Assistant Administrator. On 10/14/2021, a directed in-service on Resident's Rights, QSO 20-39NH-revised 4/27/2021, policy and procedure "COVID-19, Prevention and Control of" and "Visitation during COVID-19 Public Health Emergency(PHE)" was provided to the Administrator, Assistant Administrator and Director of Nursing by a consultant (titled- RN, NHA, RAC-CTA, DNS-CT, CLNC) not affiliated with the facility. Mandatory in-service addressing	

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F 563	Continued From page 2 resume based on the following criteria: a. If the first round of outbreak testing reveals no additional Covid-19 cases in other areas of the facility, then resume visitation in the areas/units with no COVID-19 cases. The facility will suspend visitation on the affected unit until the facility meets criteria to discontinue outbreak testing ...". Resident #138 During an interview on 9/7/21 at 1:00 PM, with Resident #138's Resident Representative revealed the facility failed to let her visit her husband during the time he was in the facility. The wife said the facility said she could come to the window and talk to him on Face Time. The wife said her husband did not have COVID-19 and his room was on the other side of the building. Record review of the Admission Record revealed Resident #138 was admitted to the facility on 4/16/21 with diagnoses that included Joint Replacement Surgery and Urinary Retention. Record review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/28/21 revealed Resident#138 had a Brief Interview for Mental Status (BIMS) score of eight (8) which indicated Resident #138's cognitive status is moderaterly impaired. During a Resident Council members meeting on 09/08/21 at 10:30 AM, the members confirmed the facility does not allow them to have visits because of the COVID-19 outbreak. The residents said they all have private rooms and they do not have COVID-19. The residents also said the facility only allowed the family to come to	F 563	Resident's Rights for all staff was conducted by the Administrator on 10/18/2021. The Administrator will ensure visitation is allowed for all residents per the CMS/CDC guidelines and policy and procedures. 4) On 10/14/2021, the Quality Assurance Committee including the Administrator, Assistant Administrator, Medical Director, Infection Control Preventionist, Director of Nursing, Social Services and Corporate Nursing Consultant met and discussed visitation and Resident's Rights. The committee reviewed the policy and procedures "Visitation during COVID-19 Public Health Emergency (PHE)"-revised September 2021 and "COVID-19, Prevention and Control of"-revised October 2021 with no recommended changes at this time. Beginning 10/14/2021, the Administrator evaluated 5 visits daily for 4 weeks and reported to the Quality Assurance Committee on 10/27/2021 that no resident was denied visitation. The Administrator will continue to monitor and report weekly through email to the QA Committee members and will continue to report for 3 months.	

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the windows of the room. They are not allowed to let the window up. They must Face Time on the phone or a computer device. The residents stated they do not understand why they can't have visitors.

During an interview on 09/8/21 at 02:12 PM, with Registered Nurse (RN) #1 confirmed the facility did not allow family visits because the facility had a COVID-19 out break starting August 3,2021. RN #1 said the facility county positivity rate is 15.2% and 85 % of the residents are vaccinated. RN #1 said the Administrator decided to not allow the families to visit. RN #1 also said the families could come to the window and Face Time the residents but the family could not enter the building.

During an interview on 09/09/21 at 02:24 PM, with the Administrator confirmed the facility did not allow visitors as of August 3, 2021. The Administrator said he knew what the latest guidance from the Centers for Medicare and Medicaid (CMS) said but he was erroring on the side of safety. The Administrator said he would rather take the tag than to see an outbreak in the building.

Resident Council Committee Members:

Resident #8:
Record review of the Admission Record revealed Resident #8 was re-admitted on 8/27/2021 with diagnoses that included Respiratory Failure, Urinary Retention, and Atrial Fibrillation.

Record review of the most recent MDS which contained a BIMS score was the 5 day Minimum Data Set (MDS) with the Assessment Reference

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Date (ARD) of 07/19/21. It revealed Resident#8 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #8 is cognitively intact.

Resident #87:
Record review of the Admission Record revealed Resident #87 was admitted on 9/02/21 with diagnoses that included Joint Replacement Surgery, Heart Disease, and Hypertension.

Observation on 9/8/21 at 10:30 AM during the Resident Council meeting revealed the Resident #87 was cognitively intact and took part in the meeting.

Resident #6:
Record review of the Admission Record revealed Resident #6 was admitted on 7/2/21 with diagnoses that included Joint Replacement Surgery, Osteoarthritis , and Hypertension.

Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/09/21 revealed Resident #6 had a Brief Interview for Mental Status (BIMS) of 15 that indicated Resident #6 is cognitively intact.

Resident #140:
Record review of the Admission Record revealed Resident # 140 was originally admitted on 4/14/21 and re-admitted on 8/23/21 with diagnoses that included Metabolic Encephalopathy, Non -Hodgkin Lymphoma and Meniere's Disease.

Record review of the most recent MDS that contained a BIMS score was the Discharge Minimum Data Set (MDS) with an Assessment Reference Date of 5/5/21. It revealed Resident

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F 563	Continued From page 5 #140 had a Brief Interview for Mental Status (BIMS) of 15 which indicated Resident #140 is cognitively intact. Resident #21: Record review of the Admission Record revealed Resident #21 was admitted on 8/7/21 with diagnoses included Respiratory Failure, Diabetes Mellitus, and Hypertension. Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date of 8/13/21 revealed Resident #21 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #21 is cognitively intact.	F 563		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		10/27/21

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F 609	Continued From page 6 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, Resident Representative interview, Sitter interview, record review and facility policy review the facility failed to report a major injury of unknown origin to the State Agency (SA) in a timely manner for one (1) of three (3) residents reviewed for injury. Resident #145 Findings Include: Record review of the facility's policy, "Incident and Accident Policy and Procedure" Reporting", undated, "Policy: It is the policy of (Formal name of Facility) shall strive to maintain an environment that promotes resident safety to ensure that each resident remains as free of acccident hazards as is possible...Procedure: 11. Incidents and accidents of suspected abuse, neglect or unexplained injury shall be reported to Mississippi State Department of Health(MSDH) with in twenty-four (24) hours of discovery (excluding Saturdays and Sundays and legal holidays) and within seventy- two (72) hours of discovery. A written report shall be completed." On 09/08/21 12:14 PM, in an interview with License Master Social Worker (LMSW) at a local hospital stated she cannot remember the resident. She stated when the Medical Doctor	F 609	1) Resident #145 was checked by the Licensed Practical Nurse immediately and not noted to have an obvious injury. She was transferred to local hospital for evaluation. 2) All residents have the potential to be affected by this deficient practice. 3) Skin assessments were completed on all residents on 10/14/2021 with no negative outcome. On 10/14/2021, residents that could be interviewed were questioned by the Assistant Director of Nursing regarding any allegation of abuse with no negative outcomes. In-service (titled Protocol for Reporting Incidents Timely) for ALL staff were initiated by the Assistant Director of Nursing on 10/14/2021 to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown origin, will be reported within two hours after the allegation is made if the allegation results in serious bodily injury or twenty-four hours if the events that cause the allegation does not result in injury.	

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F 609	Continued From page 7 (MD) sees something suspicious, he tells the LMSW to report it to the SA. She stated she remembered doing the report. She stated she goes by the Physician documentation when she calls it in to the SA. LMSW gave SA Resident #145's name. Record review of the Admission Record revealed Resident #145 was originally admitted on 12/18/19 and was re-admitted on 2/17/20. Record review of the Physician Orders, dated 2/11/20, revealed send Resident #145 to local, hospital for evaluation Review of the Physician Orders dated 2/17/20 revealed Displaced spiral fracture of shaft of right femur, Subsequent encounter for closed fracture with routine healing, and Abnormalities of gait and mobility,Muscle wasting and atrophy,need for assistance with personal care, and Alzheimer's Disease. Review of the Physician diagnosis revealed age related Osteoporosis with current pathological fracture, Unspecified site subsequent encounter for fracture with routine healing dated 12/18/19. On 9/8/21 at 2:31 PM, in an interview with Resident #145's Resident Representative (RR) stated, the sitter called and told him Resident #145 tried to get out of the bed and fell on the floor. He stated she fell in the middle of the night and broke her femur. RR #1 stated she was transferred to a local hospital. He stated the sitter told him that Certified Nursing Assistant (CNA) #4 came in to take the vital signs and left the bed rail down. RR #1 stated the sitter told him she was in the bathroom.	F 609	4) Beginning 10/18/2021, the Director of Nursing will interview 4 residents/week x 4 weeks then 4 residents/week x 2 weeks to monitor and assess residents for alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown origin, to ensure all allegations are reported per policy. The Director of Nursing will take all findings to the Quality Assurance Committee for recommendations. Weekly reports will be sent through email to the QA Committee members and will continue for 3 months.	

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On 9/8/21 at 3:33 PM, in an interview with the Director of Nursing (DON), stated the steps the nurses use for an incident are assess the resident, call the Physician, and family. She stated sitter was in the room. She stated she was told resident was found standing against the wall. She stated the nurse assessed the resident and did not find anything. She stated RP #1 came and resident was complaining of right leg pain. She stated the local hospital X-ray revealed Resident #145 had a right spiral fracture. She stated she reported to the SA state as a fall. She stated she did not send the final investigation report to the stateSA. She stated she was supposed to send it in after she completed the investigation. She stated the report should have been sent in to the SA. She stated the reason for sending it in is to show the SA the outcome of the incident and the report would show if there was abuse or neglect.

On 9/8/21 at 4:07 PM, in an interview with the DON she stated the steps she uses to investigate an incident is the following: read the incident, talk to the nurse, talk to all the people involved, find out exactly what happened, review the X ray, and get a statement from the people in the room. She stated she uses what the nurse wrote on the incident report. It happened at night. She stated she talk to the sitter. She stated she called in the incident in on 2/11/20 and faxed it on 2/14/21. She stated she did not send the results of her investigation into the SA. She stated she was supposed to send it in five (5) days.

On 9/10/21 at 8:52 AM, in a phone interview with Licensed Practical Nurse (LPN) #3 stated I do not remember the resident or incident. We had a lot of residents come and go. My mind is not as good

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as it used to be. I cannot remember anything right now.

On 9/10/21 at 11:37 AM, in an interview with CNA #4 stated when she went to answer the call light, Resident #145 was on the floor. She stated the sitter told her she heard a thump and came out of the bathroom and found the resident on the floor. She stated the nurse, sitter, and CNA #4, got the resident off the floor. She stated LPN #3 assessed the resident. She left the room during the assessment. She stated she returned to the room to check on the resident about 45 minutes after the fall and the resident was moaning. She stated she thinks she wrote a statement about the incident and gave it to the DON. She stated the resident would come out of the bottom of the bed rails. She stated that is why the resident's spouse got a sitter.

On 9/10/21 at 12:27 PM, in an interview with the sitter for Resident #145 stated, she was in the bathroom and heard a thump sound. She stated she came out of the bathroom and found the resident leaning against the wall. She stated when she saw the resident leaning on the wall, she caught the resident and they both went down on the floor. She stated the resident did not land on the floor but landed on top of her. She managed to get the resident back in the bed alone. She stated she should have got some help. I was there to prevent her from falling.

Record review of the nurses' notes dated 2/11/20 revealed about 4:20 AM, Resident #145's sitter called the nurse to come to the resident room. Resident was standing by the bedside and the sitter assisted the resident to the bed. Resident was lying on her back. Resident told the nurse

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her leg was hurting. Resident #145's knees were bent. The nurse asked the resident if she could straighten her knees out and the resident stated they are hurting. The nurse noted no open skin or tears.The nurse gave the resident Ultram as ordered for pain. Later that night the sitter called out and stated resident has a reddened area at her upper back and shoulders area. The nurse called the resident's husband and asked him about the reddened area. The sitter told the facility the resident's family wanted her sent out to a local hospital for X-ray.

On 9/10/21 at 2:58 PM, in an interview with the DON stated she called the nurse to find out what happened that night. She stated LPN #3, did not do an incident report. She stated normally the nurse does the incident report. She stated she filled the incident report out. She stated she investigated the incident as a fall. She stated she usually get a witness statement from all those involved if they witness the incident. She stated she filled out the report because the nurse did not fill it out. Normally the staff fills it out. If an injury occurs, that staff calls me and lets me know. She stated she did not get any statements from the witnesses. She stated what she did was not a thorough investigation.

On 9/10/21 at 3:03 PM, in an interview with the Administrator stated I cannot remember. I cannot recall if I was informed of the incident.

On 9/13/21 at 8:05 AM, in a post survey interview with the Sitter for Resident #145, she stated Resident #145 was on the floor when she came out of the bathroom. She stated she believes the resident climbed over the rail. She stated she told LPN #3 that the Resident #145 had fallen on the

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F 609	Continued From page 11 floor, and she picked her up by herself. She stated she knew she shouldn't have picked the resident up off the floor. She stated she should have gone and gotten help. She stated she told LPN #3 that she did not think the resident was okay. She stated CNA #4 and LPN #3 checked the resident. She stated she called the spouse and told him what had happened. Spouse wanted the resident sent out to the local hospital.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based staff interviews, sitter interview, record review and facility policy review the facility failed to do a thorough investigation regarding a resident with a possible fall for one (1) of three (3) residents reviewed for falls. Resident # 145	F 610	1) The Director of Nursing was in-serviced by the Corporate Nurse on 10/14/2021 on the appropriate protocol for conducting a thorough investigation into injuries of an unknown source.	10/27/21

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F 610	Continued From page 12 Findings Include: Record review of the facility's policy, "Accidents and Incidents - Investigating and Reporting", revised April 2013, revealed, "Policy Statement, All accidents or incidents involving residents ... occurring on our premises shall be investigated and reported to the Administrator. Policy Interpretation and Implementation, 1. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. 2. The following data, as applicable, shall be included on the Report of Incident/Accident form:... k. Any corrective action l. Follow up information ...". Record review of the Culic Incident Report dated 2/11/2020 revealed, "Date: 2/11/2020, Time: blank ...IF A RESIDENT, GIVE CONDITION PRIOR TO INCIDENT: Alert, Confused and Semi-Ambulatory, DESCRIPTION OF INCIDENT & TREATMENT ADMINISTERED: DON was informed from 7P nurse that resident was leaning up against the wall when sitter came out of bathroom. Sitter was unsure if resident had fallen or not. Resident was put back to bed and assessed-no injuries noted at that time. Later resident started c/o (complaint of) pain to RT (right) leg. Husband asked for resident to be transferred to (local hospital) ...Shift: 11-7, Area Incident Occurred: Resident Room, Locate Injury (body drawings were not marked), Incident result of fall: ? in yes box, Physician Notified: check mark in Yes, Treatment: (checks by) Referred to ER, Clinic, Hospital, Family Notified, State Notified ...Final Disposition ...Res. Admitted to (local hospital) ..." This was signed by the DON	F 610	2) All residents have the potential to be affected by this deficient practice. 3) Skin assessments were completed on all residents on 10/14/2021. On 10/14/2021, Residents that could be interviewed were questioned by the Assistant Director of Nursing regarding any allegations of abuse with no negative outcomes. In-service for ALL staff was initiated on 10/14/2021 by the Assistant Director of Nursing regarding protocol for investigating all incidents. 4) Beginning 10/04/2021, the Assistant Administrator will conduct audits of all incidents one time a week x 6 weeks to ensure that all incidents are investigated thoroughly. The Assistant Administrator reported all findings to the Quality Assurance Committee on 10/27/2021 and will continue to monitor and report weekly through email to the QA Committee members for 3 months.	

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and Administrator on 2/11/2020.

Record review of the Facility Self-Reported Incidents Information Needed checklist completed by the DON revealed, " ...Date of Incident - 2-11-2020, Incident Type - Fracture, ...Diagnosis - Acute RT spiral femur fx(fracture), admitted with Left Pubis fx, Depressive d/o (disorder), anxiety, Alzheimers, Muscle wasting, Osteoporosis, hx of mult (multiple) fractures, If the resident was taken to hospital or examined by a physician-Resident transported to ER and subsequently admitted ....Was a body audit performed? Yes ...Lab results or x-ray results-none for this incident ...Corrective actions-NA."

Record review of a statement written on facility letterhead by the Director of Nursing (DON), no date, revealed, "To Whom It May Concern: DON was notified the am of 2/11/20 concerning Resident (formal name). PM nurse stated that she was called to residents room per sitter. Sitter reported that resident was standing up against wall when sh came out of the restroom. Sitter assisted resident back to bed. The nurse assessed the resident and did not find any evidence of a fall. Later residents husband arrived and resident started complaining of pain to RT leg. The husband asked that resident be sent to (local hospital). Later that am DON spoke with residents husband and he stated she had a spiral RT femur fracture. Husband stated resient must have turned when she got out of bed and fell up against wall. Res is expected to readmit to our facility after surgery and is stable. Sincerely, (DON)

On 09/08/21 12:14 PM, in an interview with

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License Master Social Worker (LMSW) at a local hospital stated she cannot remember the resident. She stated when the Medical Doctor (MD) sees something suspicious, he tells the LMSW to report it to the State Agency (SA). She stated she remembered doing the report. She stated she goes by the Physician documentation when she calls it in to the SA. LMSW gave SA Resident #145's name.

Record review of the Admission Record revealed Resident #145 was originally admitted to the facility on 12/18/19 with primary diagnoses, onset date 12/18/19, to include but not limited to Unspecified fracture of left pubis, subsequent encounter for fracture with routine healing and Age-related osteoporosis with current pathological fracture, unspecified site.

Record review of the Physician Orders, dated 2/11/20, revealed transfer Resident #145 to the local hospital for evaluation.

On 9/8/21 at 2:31 PM, in an interview with Resident #145's Resident Representative (RR) stated, the sitter called and told him Resident #145 tried to get out of the bed and fell on the floor. He stated she fell in the middle of the night and broke her femur. RR #1 stated she was transferred to a local hospital. He stated the sitter told him that Certified Nursing Assistant (CNA) #4 came in to take the vital signs and left the bed rail down. RR #1 stated the sitter told him she was in the bathroom.

On 9/8/21 at 3:33 PM, in an interview with the Director of Nursing (DON), stated the steps the nurses use for an incident are assess the resident, call the Physician, and family. She

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stated sitter was in the room. She stated she was told resident was found standing against the wall. She stated the nurse assessed the resident and did not find anything. She stated RP #1 came and resident was complaining of right leg pain. She stated the local hospital X-ray revealed Resident #145 had a right spiral fracture. She stated she reported to the State Agency (SA) as a fall. She stated she did not send the final investigation report to the state SA. She stated she was supposed to send it in after she completed the investigation. She stated the report should have been sent in to the SA. She stated the reason for sending it in is to show the SA the outcome of the incident and the report would show if there was abuse or neglect.

On 9/8/21 at 4:07 PM, in an interview with the DON she stated the steps she uses to investigate an incident is the following: read the incident, talk to the nurse, talk to all the people involved, find out exactly what happened, review the X ray, and get a statement from the people in the room. She stated she uses what the nurse wrote on the incident report. It happened at night. She stated she talked to the sitter. She stated she called in the incident in on 2/11/20 and faxed it on 2/14/21. She stated she did not send the results of her investigation into the SA. She stated she was supposed to send it in five (5) days.

On 9/10/21 at 8:52 AM, LPN #3 in a telephone interview, stated I do not remember the resident or incident. We had a lot of residents come and go. My mind is not as good as it used to be. I cannot remember anything right now.

On 9/10/21 at 11:37 AM, in an interview with CNA #4 stated when she went to answer the call light,

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Resident #145 was on the floor. She stated the sitter told her she heard a thump and came out of the bathroom and found the resident on the floor. She stated the nurse, sitter, and CNA #4, got the resident off the floor. She stated LPN #3 assessed the resident. She left the room during the assessment. She stated she returned to the room to check on the resident about 45 minutes after the fall and the resident was moaning. She stated she thinks she wrote a statement about the incident and gave it to the DON. She stated the resident would come out of the bottom of the bed rails. She stated that is why the resident's spouse got a sitter.

Record review of the Minimum Data Set (MDS) with and Assessment Reference Date of 12/24/19 revealed a Brief Interview of Mental Status score of double zero (00) indicating Resident #145 was non-interviewable.

Record review of the nurses' notes dated 2/11/20 revealed about 4:20 AM, Resident #145's sitter called the nurse to come to the resident room. Resident was standing by the bedside and the sitter assisted the resident to the bed. At this time resident was lying on her back. Resident said her leg was hurting. She had them bent at the knees. The nurse asked the resident if she could straighten her knees out and the resident stated they are hurting. The nurse noted no open skin or tears. The nurse gave the resident Ultram as ordered for pain. Later that night the sitter called out and stated resident has a reddened area at her upper back in her shoulder area. She called the resident's husband and asked him if he knew about the red area. The sitter told the nurse that the resident's family wanted her sent out to a local hospital for X-ray. Resident #145 was

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transported to the local ER for evaluation.

On 9/10/21 at 2:58 PM, in an interview with the DON stated she called the nurse to find out what happened that night. She stated LPN #3 did not do an incident report. She stated normally the nurse does the incident report. She stated she filled the incident report out. She stated she investigated the incident as a fall. She stated she usually gets a witness statement from all those involved if they witness the incident. She stated she filled out the report because the nurse did not fill it out. Normally the staff fills it out. If an injury occurs, that staff calls me and lets me know. She stated she did not get any statements from the witnesses. She stated what she did was not a thorough investigation.

On 9/10/21 at 3:03 PM, in an interview with the Administrator stated I cannot remember. I cannot recall if I was informed of the incident.

On 9/13/21 at 8:05 AM, in a post survey interview with the Sitter for Resident #145, she stated Resident #145 was on the floor when she came out of the bathroom. She stated she believes the resident climbed over the rail. She stated she told LPN #3 that the Resident #145 had fallen on the floor, and she picked her up by herself. She stated she knew she shouldn't have picked the resident up off the floor. She stated she should have gone and gotten help. She stated she told LPN #3 that she did not think the resident was okay. She stated CNA #4 and LPN #3 checked the resident. She stated she called the spouse and told him what had happened. Spouse wanted the resident sent out to the local hospital.

Review of Resident #145's discharge instructions

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F 610	Continued From page 18 from the hospital, (not the name of the form in attachments) dated 2/17/20, revealed Resident#145 had a closed displaced spiral fracture of shaft of right femur.	F 610		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		10/27/21

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F 656	Continued From page 19 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review and facility policy review the facility failed to follow the comprehensive care plan by not securing a foley catheter tube to the residents leg and by not ensuring a resident received bi-level positive airway pressure (BIPAP) respiratory therapy for two (2) or 25 care plans reviewed, Resident #9 and Resident # 11. Resident #11 Findings Include: Record review of the facility's policy for "Minimum Data Set (MDS) and Care Plan Responsibilities" revealed no date for the policy. The policy stated, "it is the policy of the facility to develop a comprehensive care plan for each resident to provide the highest level of functioning for the resident to attain." Record review of Resident #11's Care Plan initiated 07/27/21 revealed, "Focus, Indwelling Urinary Catherization Status; urinary retention, Goal, Resident will have no complications associated with urinary catherization through next review date. Target Date: 10/26/2021, Interventions ...Catheter care per routine each	F 656	1) A leg strap was applied to Resident #11 on 9/10/2021 in order to secure the foley catheter tube to the resident's leg. The BiPap for Resident #9 was discontinued on 9/9/2021. 2) All residents have the potential to be affected by this deficient practice. 3) On 9/13/2021, the Director of Nursing completed an audit of care plans with no negative findings. The MDS Nurse conducted an in-service on 10/18/2021 on the protocol for locating and reviewing care plans with the certified nursing assistants and the facility nurses. 4) Beginning 10/18/2021, the Director of Nursing/Assistant Director of Nursing will conduct audits on 5 resident care plans a week x 4 weeks then 3 residents a week x 2 weeks. The Director of Nursing will report to the Quality Assurance Committee weekly and will continue weekly reporting through email to the QA Committee members and will continue this for 3 months.	

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shift ...Keep catheter tubing secured to leg to prevent friction and discomfort ..."

Observation on 09/09/21 at 09:32 AM, during of catheter care with Certified Nursing Assistant (CNA) #1 revealed CNA #1 failed to secure the tubing near the meatus while cleaning the tubing on the catheter. CNA #1 pulled on the tube with a wet wipe cloth. During the care the catheter bag was attached to the left side of the bed frame. CNA #1 turned the resident to the right side to cleanse Resident #11's buttocks. CNA #1 did not transfer the catheter bag to the right of the bed. The catheter tubing tugged tightly on the meatus. Resident #11 did not have a leg strap on to secure the catheter to prevent friction.

Record review of the Admission Record revealed Resident #11 was admitted to the facility on 7/15/2021, with the diagnoses that included but not limited to Acute Kidney Failure, Retention of urine, and Anxiety disorder.

The Admission Minimum Data Set (MDS) with the an Assessment Reference Date (ARD) of 07/22/21 revealed Resident#11 had a Brief interview of for Mental Status (BIMS) of 7 that indicated Resident #11 is cognitively impaired.

During an interview on 09/9/21 at 02:50 PM, CNA #1 confirmed Resident #11
did not have a leg strap or securing device to her leg to prevent friction. CNA #1 said the resident has not had one every since she was admitted. CNA #1 said she did not know the resident needed a securing device because it was not on her care plan. CNA #1 confirmed she did not secure the resident tubing while cleaning it and the tubing was tugging tightly to on the meatus.

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CNA #1 also confirmed the tubing was tugging tightly on the resident when she turned her to the right side and cleansed the resident's buttocks.

During an interview on 09/09/21 at 3:08 PM, Interview with Registered Nurse (RN) #1 confirmed CNA #1 did not have the securing device on the CNA's care plan. RN #1 said she thought the orders automatically transferred to the CNA's task/care plan. RN #1 said this would be corrected as of today.

During an interview on 09/09/21 at 03:10 PM, with the Director of Nursing (DON) confirmed CNA #1 failed to follow the Comprehensive Care Plan by not securing the catheter to Resident #11 leg and not holding the tip of the tubing near the meatus while providing catheter care. The DON said that could have caused the catheter friction and possible trauma to the meatus. The DON also said CNA #1 should have put the catheter bag on the right side of the bed frame to prevent the catheter from tugging on the meatus. The DON revealed she was not aware the catheter care did not transfer from the comprehensive care plan to the CNA's task/care plan.

During an interview on 09/10/21 at 12:51 PM, RN #2 said he expected the staff to follow the comprehensive care plan. RN #2 confirmed CNA #2 did not follow the care plan because the care plan states the staff should keep catheter tubing secured to the leg to prevent friction and discomfort. RN #2 also stated that the CNA's and floor nurses are responsible for making sure the residents have a securing device connected to their leg to prevent tugging and friction. RN #2 also said this could cause trauma and or infection.

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Resident #9

Record review of Resident #9's Comprehensive Care Plan initiated 7/27/21 revealed problem, "Oxygen therapy due to Acute Hypoxic Respiratory Failure" and included the intervention/task "BIPAP/CPAP (Bi-level positive airway pressure/Continuous positive airway pressure) at night. Resident may manage device. Offer assistance as needed."

During an observation and interview on 09/07/21 at 03:00 PM, the State Survey Agency (SSA) observed Resident #9 lying in bed. Resident #9 reported the BIPAP machine is new, and she has never worn it at this facility. She explained no one knows how to work it. She explained a guy just brought the supplies and set the numbers and she tried it on, but she told him something is not right with the setting or the mask, but it does not feel right. She reported he told her the setting are correct and done nothing else and left. She reported she didn't wear her BIPAP that night because when she asked the nurse, she said she didn't know anything about the settings but knows how to put it on.

On 09/08/21 at 8:30 AM, the SSA observed Resident #9 sitting up wheelchair with oxygen in use at 2L/min (liters per minute) via nasal cannula. Resident #9 reported she did not use the BIPAP last night.

In an interview on 09/08/21 at 4:30 PM, with Resident #9, she explained she has never refused wearing the BiPAP but has not worn BiPAP since she has been here. She explained

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the settings for the machine was either too high when the little guy set up the machine or something because it just didn't feel or work right. She explained she used the BiPAP while at the other place but reported it just didn't work right at this place. She explained when staff would ask her if she wanted to wear BiPAP, she explained she only asked if they knew how to do the settings. She explained the nurses would just look confused. She explained the Director of Nurse (DON) did come and ask her about the mask but she explained it was not the mask, but it was the air flow and the settings. She explained no one else ever talked to her about the BiPAP machine.

On 09/09/21 at 08:50 AM, during an interview with DON, when asked her the purpose of the care plans and physician orders, she explained to ensure the resident receives care to benefit the resident. When asked if a resident refused a treatment what should happen, she explained the physician should be notified and the care plan revised as needed.

On 09/10/21 at 12:50 PM, during an interview with Registered Nurse #2, he explained all staff should follow physician orders and care plans for each resident and if not followed there could be a problem with the resident's health. When asked if a resident has a physician order for a BIPAP should that be included in the care plan,he explained all interventions should be included on the resident's care plan. When asked if a resident continue to refuse a medication or treatment what should be done, he explained the physician should be notified and a care plan should be revised.

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 _____	C 09/10/2021

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 656	Continued From page 24	F 656		

Record review of Resident #9's Admission Record revealed the facility admitted Resident #9 on 07/15/21 with the diagnoses of Acute Respiratory failure with hypoxia, Anxiety, Major depressive disorder, Alcohol abuse, Obesity, Presence of artificial hip joint bilateral, Steven-Johnsons Syndrome, and Congestive Heart Failure.

Record review of Resident #9's hospital discharge instructions dated 7/15/21, revealed "...BIPAP during hours of sleep or when experiencing shortness of breath or sleepiness....Your settings are 15/8/40%...when not using the BIPAP please use oxygen at two (2) liters per minute via nasal cannula."

Record review of Resident #9's Order Summary Report dated 7/15/21, revealed orders for "BIPAP on at bedtime...oxygen at two (2) liters per minute via nasal cannula every shift."

Record review of Resident #9's Admission MDS with ARD of 07/22/21, Section C revealed a Brief Interview of Mental Status (BIMS) score of 15, which indicated Resident #9 is cognitively intact.