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	61WG	A. BUILDING: _____ B. WING _____	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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M 000	Initial Comments The State Agency(SA) conducted an annual recertification survey along with complaint investigations MS #17888, MS #17870 and MS #16634 at the facility from 9/7/2021 to 9/10/2021. During the compliant investigation, the SA determined the facility was not in complaince with the Minimum Standards for Operation for Institutions for the Aged or Infirm state licensure requirements. MS #17870 and MS #16634 were substaintated related to abuse and visitiation and cited M500. MS#17888 for resident/patient treatment with dignity and respect, Rehabilitation, Quality of care and treatment, and injury of unknown origin was not substaintaed. The SA also cited M620 and M655 during the survey. The facility held a license for 52 with a census of 38.	M 000		
M 620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. Level II Based on observation, interviews, record review and facility policy review the facility failed to anchor a Foley catheter tube securely while performing catheter care and failed to secure the tubing with a catheter leg strap for one (1) of three (3) catheter observations. Resident #11 Findings include: Record review of the facility's" Catheter Care"	M 620	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. 2) All residents with indwelling catheters have the potential to be affected by this deficient practice. 3) The CNA #1 was in-serviced on securing the catheter tubing on the resident's leg and securing the tip of the catheter during care on 9/10/2021 by the	10/27/21

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M 620	Continued From page 1 undated, revealed "Policy: it is the policy of the facility to ensure that residents with indwelling catheters recieve appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. Policy Explanation:1. Catheter care will be performed every shift and as needed by nursing personnel...Female: 12. ... with a new moistened cloth, starting at the urinary meatus moving out, wipe the catheter making sure to hold catheter in place so as to not pull on the catheter..." Resident #11 Observation on 09/09/21 at 09:32 AM, of catheter care with Certified Nursing Assistant (CNA) #1 revealed CNA #1 failed to secure the catheter tubing near the meatus while cleaning the tubing. CNA #1 pulled on the catheter 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 buttocks. CNA #1 did not transfer the catheter bag to the right side 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. 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 a securing device on since she was admitted. The CNA confirmed she did not secure the resident tubing while cleaning it and the tubing was tugging tightly to the meatus. CNA #1 also confirmed the tubing was tugging tightly on the resident when she turned her and cleansed the tubing.	M 620	Assistant Director of Nursing. An immediate in-service was held on 9/10/2021 with all floor nurses and CNAs regarding the protocol for catheter care by the Assistant Director of Nursing. 4) Beginning 10/18/2021, the Assistant Director of Nursing will observe catheter care on 2 residents weekly x 4 weeks and 1 resident weekly for 2 weeks. The Assistant Director of Nursing will report to the Quality Assurance Committee weekly through email to the members and this will continue for 3 months.	

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M 620	Continued From page 2 During an interview with RN #1 on 09/09/21 at 3:08 PM, revealed the facility does catheter training with the staff once a year. RN #1 confirmed CNA #1 should have secure the tubing at the tip near the meatus to prevent it from coming out or causing infection. RN #1 said CNA #1 should have removed the catheter bag from the bed frame on the left side when she turned the resident and placed it on the right side of the bed frame to keep the catheter from tugging tightly. During an interview 09/09/21 at 03:10 PM, with the Director of Nursing (DON) The DON said CNA #1 should have held the tip of the catheter near the meatus while wiping the tubing to prevent friction. 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. 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. 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 shift ...Keep catheter tubing secured to leg to prevent friction and discomfort ..." Record review of the Admission Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 07/22/21 revealed Resident#11 had	M 620		

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M 620	Continued From page 3 Brief Interview for Mental Status (BIMS) score of 7 that indicated Resident #11 has moderate cognitive impairment.	M 620		
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Level II Based on observation, staff interviews, record review and facility policy review the facility failed to ensure a resident who was physician ordered to receive respiratory services of bi-level positive airway pressure (BIPAP) machine received this service for one (1) of three (3) residents reviewed. Resident #9 Findings include: Record review of the facility's policy for "Refusal of Medication and Treatments" with a revision date of 09/11 revealed six key elements including, ..." Refusals of treatment should be countered by discussion with the resident of the health and safety consequences of the refusal and the availability of any therapeutic alternatives that might exist. Physician and Responsible Party must be notified..." During an observation and interview on 09/07/21	M 655	1) Resident #9 received an order on 9/9/2021 from the medical provider to discontinue the BiPap per resident's request. 2) All residents have the potential to be affected by this deficient practice. 3) An in-service for all nurses was conducted on 10/14/2021 by the Director of Nursing regarding the protocol to follow Physician's orders. 4) Beginning 10/18/2021, the Director of Nursing and the Assistant Director of Nursing will conduct audits of the Physician's orders on 4 residents weekly x 4 weeks and 3 residents weekly x 2 weeks. The Director of Nursing and the Assistant Director of Nursing will report to the Quality Assurance Committee weekly through email and will continue to report weekly for 3 months.	10/27/21

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M 655	Continued From page 4 at 03:00 PM, revealed 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 did 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 setting but knows how to put it on. On 09/08/21 at 4:30 PM, interview with Resident #9, she explained she has never refused wearing BIPAP but has not worn BIPAP since she has been here. She explained the settings for the machine was either too high when the 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 the BIPAP, she explained she only asked if they knew how to do the settings, she explained the nurses would just look confused and would say nothing. She explained the Director of Nurses(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 09/08/21 at 05:00 PM, during an interview with the Assistant Director of Nurses (ADON), when asked if a resident refused oxygen what the facility would do, she explained the doctor would be notified on the first day of refusal so the doctor	M 655		

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can evaluate and determine if the resident needs the oxygen. She further explained either a Physician or a Nurse Practitioner is here at the facility almost every day and at least weekly. She explained the nursing staff also communicates with the physicians through an app to get in touch or send a message regarding a resident. She explained she did not know anything about Resident #9 not wearing her BIPAP or any problems with the machine. She reviewed the resident's Medication Administration Record (MAR) and explained it only shows that the resident has not received her BIPAP several times since admission. She explained if the resident did not want to wear the BIPAP the Nurse Practitioner or Physician should had been notified but explained there is no documentation of the physician being notified.

On 09/09/21 at 8:40 AM, during an interview with Licensed Practical Nurse (LPN) #1, Admission Nurse, she explained she did work a night shift around 08/04/21 and when she went to try and put on the BIPAP, Resident #9 complained of the BIPAP not fitting correctly but never did mentioned anything about the settings. She explained she did not notify the Physician or Nurse Practitioner about the resident not wearing BIPAP but did report the incident to the DON.

On 09/09/21 at 08:50 AM, during an interview with the DON, she explained she did go and talk to Resident #9 after LPN #1/Admission Nurse reported to her Resident #9's complaints regarding BIPAP not fitting right. She explained when she spoke to Resident #9, resident denied any problems with the settings for the BIPAP. The DON explained she offered to reorder another mask for the machine, but resident denied wanting a new mask. The DON further

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explained after she spoke to the resident she just forgot about the situation and did not think any more about it and no one else mentioned anything about the BIPAP.

On 09/09/21 at 2:30 PM, during an interview with Physician #1, he explained he has seen Resident #9 several times and spoke to the resident and her daughter about the disease process of Steven-Johnsons Syndrome. He explained the resident was seen on 08/14/2021 and 08/19/2021 regarding shortness of breath and had a chest x-ray. He explained Resident #9 would have benefited from receiving the BIPAP. He further reported he was not aware Resident #9 was not receiving the BIPAP as ordered and if she was not wanting to use it the BIPAP could have been discontinued.

On 09/10/21 at 2:50 PM, during an interview with Resident #9's Resident Representative (RR), her daughter revealed she explained she has spoken to the doctor regarding her mother's lung disease but no one ever mentioned to her about her mother not wearing her BIPAP.

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

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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 Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 07/22/21 Section C revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated resident is cognitively intact. Section O of the MDS revealed only oxygen marked for special treatments and the section for BIPAP was not marked.

Record review of Physician Progress note dated 08/19/21 revealed Resident #9 had complaints of shortness of breath and was treated for Congestive Heart Failure. The progress note did not mention the use of the BIPAP.

Record review of Resident #9's MAR for July and August 2021 revealed the resident wore BIPAP for total of six (6) times.

Record review of nurse progress note for 08/04/21 revealed "resident did not wear BIPAP all night and was having increased anxiety ..."

Record review of Resident #9's Medication Administration Record (MAR) dated July 2021 revealed, "BIPAP ON at bedtime, Start Date-07/15/2021". Resident #9's MAR indicated that the resident wore the BIPAP three (3) times on 7/15/21, 7/19/21 and 7/202/1. Resident #9 had 13 days recorded as a "9" indicating "other" and 1 day on 7/29/21 recorded as "2" indicating "Refused". Record review of Resident #9's MAR

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M 655	Continued From page 8 dated August 2021 revealed that the resident wore the BIPAP three (3) times on 8/22/21, 8/25/21 and 8/30/21. Resident #9 had 17 days coded as a "9" indicating "other", 10 days coded "2" indicating "Refused, and one (1) day on 8/7/21 coded as a "5" indicating "Hold/See Nurses Note". The #9, "other" is not included in the legend on the MAR.	M 655		