

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                          |  |                                                                        |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255300</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>03/13/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WILLOW CREEK RETIREMENT CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>49 WILLOW CREEK LANE<br/>BYRAM, MS 39272</b>                             |  |                                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                                             |
| F 000                                                                     | INITIAL COMMENTS<br><br>The State Agency (SA) conducted four (4) Complaint Investigations (CI MS #24189, CI MS #23825, CI MS #23818 and CI MS #23449), at the facility from 3/11/24 through 3/13/24. CI MS #24189 was investigated for Resident Neglect related to Pressure Sores. CI MS #23825 was investigated for Quality of Care regarding resident left wet for extended periods and no pressure sore precautions. CI MS #23818 was investigated for Accidents related to Falls. CI MS #23449 was investigated for Resident Neglect regarding Pressure Sores and for Quality of Care/Treatment regarding resident left wet for extended periods and inappropriate feeding assistance. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited deficient practice at F686 related to CI MS #24189 and MS #23449. During the survey, F690 was also cited, unrelated to the complaint investigation.<br><br>The facility held a license for 88 beds, with a census of 77. | F 000                                                                      |                                                                                                                          |  |                                                                        |
| F 686<br>SS=D                                                             | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | F 686                                                                      |                                                                                                                          |  | 4/15/24                                                                |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/28/2024

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                            |                                                                        |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|------------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255300</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>03/13/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WILLOW CREEK RETIREMENT CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>49 WILLOW CREEK LANE<br/>BYRAM, MS 39272</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                            |                                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X5)<br>COMPLETION<br>DATE |                                                                        |
| F 686                                                                     | <p>Continued From page 1</p> <p>with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interviews, record review, and facility policy review, the facility staff failed to provide treatment and services in a manner to promote the healing and prevent complications of a pressure ulcer for one (1) of three (3) sampled residents with pressure ulcers. (Resident #2)</p> <p>Findings include:</p> <p>Review of the facility's policy, titled "Dressing Change" undated, revealed, "Policy: A dressing change will be done to promote wound healing, prevent infection and to provide an opportunity for wound assessment ..."</p> <p>Review of the facility's policy, titled "Hand Hygiene, reviewed 6/12/22, revealed "Policy: All staff will perform hand hygiene procedures to prevent the spread of infection...Policy Explanation and Compliance Guidelines: 6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves."</p> <p>On 3/13/24 at 11:55 AM, an observation revealed the facility Treatment Nurse provided wound treatment for a Stage 2 pressure ulcer, with non-intact skin on the left upper back of Resident #2. After the Treatment Nurse removed the dressing from the wound, she removed her gloves and donned (put on) clean gloves without performing hand hygiene. During the procedure,</p> | F 686                                                                      | <p>1. Immediate action(s) taken for the resident(s) found to have been affected include:<br/>The Director of Nursing Services (DNS) assessed resident #2 for any adverse outcomes related to the alleged deficient practice. The Treatment Nurse was in-serviced on proper handwashing and dressing changes on 3/13/2024. Following the in-service a competency assessment of proper handwashing and dressing changes was completed on 3/13/2024 by the DNS.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by:<br/>The facility has determined that all residents with wounds have the potential to be affected. A review of physician orders in the electronic medical record was completed on 3-14-24 to identify potentially affected residents.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include:<br/>All licensed nurses providing wound care were in-serviced on the facility's policy on dressing changes and proper handwashing with donning/doffing gloves. In-services began on 3/13/2024 with the nurses working. All other nurses were in-serviced prior to next patient care assignment.<br/>On 3-22-24, the Quality</p> |                            |                                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                            |                                                                        |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|------------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255300</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>03/13/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WILLOW CREEK RETIREMENT CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>49 WILLOW CREEK LANE<br/>BYRAM, MS 39272</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                            |                                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X5)<br>COMPLETION<br>DATE |                                                                        |
| F 686                                                                     | <p>Continued From page 2</p> <p>the Treatment Nurse dropped the sterile calcium alginate dressing on the mattress, picked the dressing up and applied the dressing to the wound. The Calcium Alginate dressing was larger than the wound. The adhesive and edge of the Calcium Alginate bordered dressing used to cover the wound protruded past the wound margins.</p> <p>Record review of the "Instructions For Use" on the Calcium Alginate dressing package revealed " ...Make sure the dressing DOES NOT overlap the wound margins..."</p> <p>On 3/13/24 at 12:30 PM, during an interview with the Treatment Nurse, confirmed she had not performed hand hygiene after removal of the dressing from the resident's wound and removing her gloves, prior to donning fresh gloves and applying the calcium alginate dressing. The Treatment Nurse stated that she did not perform hand hygiene because the hand sanitizer was in a wall mounted dispenser, located next to the door, and she did not want to leave her clean field to use the hand sanitizer or the bathroom sink. The Treatment Nurse did not respond regarding the application of the Calcium Alginate dressing to the resident's wound, after being dropped on the mattress, nor did she respond to the Calcium Alginate dressing overlapping the wound margins.</p> <p>On 3/13/24 at 4:55 PM, in an interview the Director of Nurses (DON) confirmed that the facility policy on hand hygiene stated that hand hygiene was to be performed upon removal of used gloves and prior to the donning of clean gloves.</p> <p>A record review of the "Face Sheet" for Resident</p> | F 686                                                                      | <p>Assurance/Performance Improvement (QAPI) Committee reviewed the dressing changes and proper handwashing with donning/doffing gloves policies. There were no recommended changes to the policy.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The Director of Nursing Services (DNS) or Assistant Director of Nursing Services (ADNS) will make rounds with wound care nurse weekly for four consecutive weeks beginning on 3/14/24 and ending on 4-12-24. No less than three residents weekly will be monitored for proper handwashing techniques and utilization of wound dressing per manufacturer's instructions. Results of the weekly monitoring will be reviewed daily in Clinical Meeting.</p> <p>The in-service and weekly wound care monitoring will be reviewed in the QAPI meeting held on 4/15/24 to determine substantial compliance. Monthly wound care monitoring will continue for two additional months to ensure treatment nurses are providing wound care in accordance with facility policies. The results of monthly wound care monitoring will be reviewed by the QAPI Committee monthly for two months.</p> |                            |                                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                          |                            |                                                                        |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|------------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255300</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>03/13/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WILLOW CREEK RETIREMENT CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>49 WILLOW CREEK LANE<br/>BYRAM, MS 39272</b>                             |                            |                                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                                        |
| F 686                                                                     | Continued From page 3<br><br>#2 revealed the facility admitted the resident on 9/15/23. The resident had diagnoses that included Pressure Ulcer of Unspecified Part of Back, Stage 2, Venous Insufficiency, and Type 2 Diabetes Mellitus.<br><br>A record review of the March 2024 "Physician Orders," for Resident #2 revealed an order dated 3/05/24 "Clean Left upper back Stage 2 pressure ulcer with normal saline, apply Aquacel AG (Calcium Alginate) and cover with outer dressing. Change daily and PRN (as needed)."                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | F 686                                                                      |                                                                                                                          |                            |                                                                        |
| F 690<br>SS=D                                                             | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary;<br>and<br>(iii) A resident who is incontinent of bladder | F 690                                                                      |                                                                                                                          | 4/15/24                    |                                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                        |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255300</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>03/13/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WILLOW CREEK RETIREMENT CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>49 WILLOW CREEK LANE</b><br><b>BYRAM, MS 39272</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | (X5)<br>COMPLETION<br>DATE                                             |
| F 690                                                                     | <p>Continued From page 4</p> <p>receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interviews, record review, and facility policy review, the facility failed to provide care and services for a resident with an indwelling urinary catheter in a manner to prevent the potential for a urinary tract infection (UTI) for one (1) of two (2) sampled residents with indwelling urinary catheters. (Resident #6)</p> <p>Finding include:</p> <p>Record review of the facility policy titled, "UTI Prevention with Indwelling Catheter Use," dated 1/27/2015, revealed, "Policy: A resident with an indwelling catheter is susceptible to urinary tract infections... Policy Explanation ... 3. Urinary drainage tubing should be positioned so as not to touch the floor..."</p> <p>On 3/12/24 at 12:40 PM, an observation revealed Certified Nursing Assistant (CNA) #1 answered the call light for Resident #6, who was seated on the toilet in her room. The resident's catheter drainage bag and approximately three (3) inches of drainage tubing were lying on the floor next to the toilet.</p> | F 690                                                                      | <p>1. Immediate action(s) taken for the resident(s) found to have been affected include:<br/>The certified nursing assistant (CNA) identified was immediately in-serviced on the facility's policy on Urinary Tract Infection (UTI) prevention with indwelling catheter use.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by:<br/>The facility has determined that any resident with an indwelling catheter is at risk. A review of physician orders in the electronic medical record was completed on 3-14-24 to identify all residents potentially affected.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include:<br/>On 3-12-24 CNA #1 was in-serviced on the facility's UTI prevention with indwelling catheter use policy. All CNA's and nurses working on 3-12-24 were in-serviced on the importance of not allowing the urinary drainage tubing to</p> |  |                                                                        |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                            |                                                                        |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|------------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255300</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>03/13/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WILLOW CREEK RETIREMENT CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>49 WILLOW CREEK LANE<br/>BYRAM, MS 39272</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                            |                                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X5)<br>COMPLETION<br>DATE |                                                                        |
| F 690                                                                     | <p>Continued From page 5</p> <p>On 3/12/24 at 12:45 PM, in an interview with CNA #1, she confirmed the catheter drainage bag and tubing should not have been on the floor due to the risk of urinary tract infection.</p> <p>On 3/13/24 at 4:20 PM, an interview with Medical Doctor (MD) #1, he confirmed that catheter drainage bag and tubing should be kept off of the floor due to the risk of urinary tract infection.</p> <p>On 3/13/24 at 4:55 PM, during an interview the Director of Nurses (DON) confirmed that catheter drainage bags and drainage tubing should not be on the floor and that bags and tubing laid on the floor could increase the risk of a urinary tract infection.</p> <p>Record review of the "Face Sheet" for Resident #6 revealed the facility admitted the resident to the facility on 11/21/23, with diagnoses that included Unspecified Hydronephrosis and Cognitive Communication Deficit.</p> <p>Record review of the March 2024 "Physician Orders" revealed, an order dated 11/21/23 "Insert 16F (French, size of catheter) 10cc (centimeter) bulb indwelling foley catheter r/t (related to) hydronephrosis."</p> | F 690                                                                      | <p>touch the floor due to increased risk of urinary trac infection. All other direct care staff were in-serviced prior to next patient care assignment. In-service training included observation of each CNA performing the procedure. A Validation Checklist was completed for every CNA to determine if the individual was performing the procedure correctly.</p> <p>On 3-22-24 the Quality Assurance/Performance Improvement (QAPI) Committee reviewed the UTI prevention and indwelling catheter use policy with no recommended changes to the policy.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The Director of Nursing Services (DNS) or Assistant Director of Nursing Services (ADNS), will complete weekly validation checklists of CNAs performing perineal care weekly for four consecutive weeks beginning on 3/15/2024 and ending on 4/12/24. Results of those weekly validation checklists will be reviewed in daily Clinical Meeting.</p> <p>The in-service and weekly validation checklists will be reviewed in the QAPI meeting held on 4/15/24 to determine substantial compliance. Monthly validation checks will continue for three months to ensure CNAs are performing perineal care in accordance with our facility's policy. The Validation checklists will be reviewed by the QAPI Committee monthly for two months.</p> |                            |                                                                        |