MSDH - Health Facilities Licensure and Certification

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 25WC | A. BUILDING: _____ B. WING _____ | C 05/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WILLOW CREEK RETIREMENT CENTER | 49 WILLOW CREEK LANE BYRAM, MS 39272 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| M 000 | Initial Comments<br><br>The State Agency (SA) conducted a Complaint Investigation (CI), MS #24849 at the facility from 5/23/24 through 5/24/24. CI MS #24849 was investigated related to resident neglect and quality of care related to client services not provided per care plan and physician orders and for responsible party not notified of resident change of condition. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and cited M615. | M 000 | | |
| M 615 | 45.21.3 Pressure sores<br><br>Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable.<br><br>This Statute is not met as evidenced by:<br>Level II<br><br>Based on observations, record review, interviews, and facility policy review, the facility failed to provide care and services to promote healing and prevent infection for one (1) of four (4) residents that required wound care. Resident #2<br><br>Findings Include:<br><br>Record review of the facility policy titled "DRESSING CHANGE," (undated), revealed, "A dressing change will be done to promote wound healing, prevent infection and to provide an opportunity for wound assessment." | M 615 | 1. Dressing changes were completed on resident #2 on May 23, 2024 by Registered Nurse (RN) #1. And, a full-time Treatment Nurse was hired, effective 6.18.2024.<br><br>2. All residents with wounds have the potential to be affected.<br><br>3. Full-time wound care nurse appointed, effective 6.18.2024, until then part-time RN will be performing dressing changes, effective 5.23.2024. Also, weekly visits by | 7/4/24 |

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| M 615 | Continued From page 1<br><br>On 5/23/24 at 3:50 PM, an observation of Resident #2 revealed she was lying on her back in bed. The resident's incontinence brief was wet and had fecal matter present. There were two small open areas on her sacral area, with no bandage present.<br><br>On 5/23/24 at 4:55 PM, an interview with the Assistant Director of Nurses (ADON) revealed she was assigned to the care of Resident #2 on 5/23/24. She stated she had not provided wound care to Resident #2. She explained that she intended to wait because evening meal trays had just been delivered to the hall and she had to assist with meal deliveries. She stated, "when trays come out, everyone stops doing what they're doing and passes trays," as she continued to retrieve meal trays from the cart.<br><br>On 5/23/24 at 5:25 PM, an interview with the ADON revealed that Resident #2 had not yet had wound care to her sacral area on . She confirmed that the resident had not had a dressing in place from 3:50 PM until 5:25 PM. She also confirmed that Resident #2 was always incontinent of bowel and bladder.<br><br>On 5/24/24 at 5:55 PM, in an interview with the ADON, she revealed Resident #2 received sacral wound care and her sacral dressing had been replaced after 5:30 PM, by Registered Nurse (RN) #1.<br><br>On 5/24/24 at 2:00 PM, an interview with RN #1 revealed that she had performed wound care for Resident #2 on 5/23/24 after 5:30 PM. She confirmed that the resident had not had a dressing in place at the time, however, she did not know why. The nurse confirmed that it was | M 615 | the Wound Nurse Practitioner will continue. On 6.10.2024, Assistant Director of Nursing and Administrator conducted in-service education to nursing staff regarding the importance of dressing change and providing treatments, as ordered.<br><br>4. Quality Assurance Performance Improvement on Dressing Changes was initiated on 5.24.2024, with a follow-up QAPI on 6.12.2024.<br><br>DON and/or ADON will audit five residents with dressing change orders to ensure that dressings are intact 2 X week for three weeks, then weekly X two weeks, and monthly X 1 beginning 6.11.2024.<br><br>DON will report findings at the monthly Quality Assessment & Assurance (QAA) committee scheduled on 7.3.2024 for three months. | |

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| M 615 | Continued From page 2<br>important for incontinent residents, with open wounds, to have dressings in place according to physician orders to reduce the risk of infection.<br><br>On 5/24/24 at 2:10 PM, an interview with Medical Doctor (MD) #1 revealed he it was important for physician orders for dressings to open areas to the sacral area be followed to provide a barrier to prevent exposure to urine and fecal matter in residents that are incontinent of bowel and bladder. He stated that this was important to prevent infection.<br><br>On 5/24/24 at 2:30 PM an interview with the facility Administrator revealed he expected physician orders for wound care to be carried out in a manner to protect residents' skin and prevent infection. He stated that there was no facility policy in place that stated resident needs could not be provided during meal times.<br><br>Record review of the Face Sheet for Resident #2 revealed the facility admitted the resident on 2/10/21. The resident had diagnoses of Chronic Kidney disease, Venous Insufficiency, and Stage 2 pressure Ulcer of Sacral Region.<br><br>Record review of the "Physician Orders," dated May 2024, for Resident #2, revealed an order, dated 4/16/24, to "Cleanse stage 2 pressure injury to sacrum with normal saline. Pat dry with gauze. Apply foam dressing. Change daily and PRN until healed."<br><br>Record review of the Electronic Treatment Administration Record (ETAR), for May 2024, revealed RN #1 performed wound care for Resident #2 on 5/23/24. | M 615 | | |