

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25WC	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/12/2024
NAME OF PROVIDER OR SUPPLIER WILLOW CREEK RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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
M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI), MS #26369 and CI MS #26411, at the facility from 9/11/24 through 9/12/24. CI MS #26369 was investigated related to a Facility Reported Accident (FRI). CI MS #26411 was investigated related to resident neglect and resident safety, involving the FRI. During the survey, the SA determined that based on corrective actions completed by 9/5/24 prior to the SA entrance on 9/11/24, the facility was in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements with CI MS# 26369 and CI MS# 26411 and M640 was cited as Past Non-Compliance	M 000		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level III Based on interviews, record review, and facility investigation review, the facility failed to provide adequate supervision to prevent an accidental coffee burn for one (1) of the four (4) sampled residents. Resident #1 Findings included: Record review of the Facility Investigation with completion date 9/06/24 revealed the facility	M 640	No plan of correction required - Past Non-Compliance	9/25/24

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

09/25/24

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M 640	Continued From page 1 reported the incident of coffee spill with burn injury of Resident #1 to the State Agency (SA) and appropriate agencies in accordance with state and federal guidelines initially on 9/03/24 with final report submitted on 9/06/24. According to the Facility Investigation, the resident was served coffee on the morning of 9/03/24 at approximately 7:00 AM, observed capably drinking the coffee without assistance, then at 7:08 AM the resident rested the covered coffee cup on his stomach and it fell and tumbled toward the resident's left thigh, spilling and causing a burn injury to the resident, unobserved by facility staff. Further record review of the Facility Investigation included hospital progress notes and discharge instructions which revealed that Resident #1 was transported to a local acute care hospital for assessment and treatment of a twenty centimeter (cm) by sixteen cm (20cm X 16cm) partial thickness burn of left thigh of unspecified degree burn from hot coffee on 9/03/24 and was taken to surgery for debridement with application of skin substitute on 9/04/24 and was "stable and ready for discharge" on 9/05/24. Discharge instructions included deep wound clean and dry and reinforce dressing as needed. On 9/11/24 at 2:50 PM an interview with the Dietary Manager (DM) revealed that he was notified by the Administrator on 9/03/24 that Resident #1 had a burn injury that had been determined to be from the coffee. He said he notified the local vendor and was instructed to immediately remove the commercial coffee maker from service, which he did. He said the Administrator procured non-commercial coffee makers from a local vendor to provide coffee for residents over the weekend until the local vendor	M 640		

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M 640	Continued From page 2 delivered a new commercial coffee machine. He stated that he was instructed to immediately begin measuring the temperature of coffee before it was served to residents and cool the coffee to one hundred forty (140) degrees Fahrenheit or below before being sent out in carafes or served in cups to residents. He confirmed that he attended a meeting of QAPI committee on 9/05/24, during which the facility Hot Liquids Policy was revised to prevent further injury. The DM confirmed that the temperature of all coffee sent out in carafes or served in cups to residents since the afternoon of 9/03/24, had been checked and none of the coffee was above one hundred forty (140) degrees Fahrenheit. Record review of the Hot Liquids Evaluation, dated 6/17/24 for Resident #1, revealed the resident was assessed by Registered Nurse (RN) #1 as able to manage hot liquids independently with a cup with lid when drinking hot liquids and had no previous history of hot liquid spills. On 9/12/24 at 2:00 PM an interview with the Director of Nurses (DON) revealed she was made aware that Resident #1 had a skin injury on his left hip/thigh area on 9/03/24 at approximately 1:30 PM. She said she immediately assessed the resident in his bed in his room and described the injury as an open area of skin with healthy looking pink subcutaneous tissue exposed. She said that while in the resident's room she had observed a light coffee colored stain on the pad from his Geri recliner. She confirmed that she had observed security camera footage of the activity room on the morning of 9/03/24 during which the resident sat a cup of coffee on his stomach, rubbed his eyes, the coffee cup turned over and tumbled toward the side of the Geri recliner. She said that after watching the rest of the footage of the	M 640		

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M 640	Continued From page 3 Resident for 9/03/24, it was determined that the resident had experienced a burn from the coffee from the toppled coffee cup based on the determination that there was no contact with any other hot or heated objects or substances. The DON confirmed that all residents received Hot Liquids Evaluations, with care plans updated as needed. She confirmed that In-Service Training's on hot liquid services and the proposed changes to the Hot Liquid Policy were provided to all dietary and nursing staff on 9/04/24 through 9/05/24. She confirmed that she attended a meeting of the QAPI committee on 9/05/24 during which the incident and the facility's Hot Liquid Policy was reviewed, and the proposed policy revision was approved. On 9/12/24 at 2:30 PM an interview with the Administrator revealed he was notified by the DON that Resident #1 had a skin injury on 9/03/24 at approximately 1:30 PM. He said that as part of the facility investigation he observed security camera footage of the activity room on the morning of 9/03/24 during which the resident sat a cup of coffee on his stomach, rubbed his eyes, the coffee cup turned over and tumbled toward the side of the Geri recliner. He said that after watching the rest of the footage of the Resident for 9/03/24, it was determined that the resident had experienced a burn from the coffee from the toppled coffee cup, based on the determination that there was no contact with any other hot or heated objects or substances. The Administrator reported that all staff involved in the care of the resident on 9/03/24 were interviewed and that none of them had noted wetness or stain of the resident's clothes or signs and symptoms of distress or discomfort. He reported that after the resident's security was ensured, coffee temperatures were measured with the injury	M 640		

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M 640	Continued From page 4 reported to the local vendor, who issued instructions for the coffee maker be removed from service. The commercial coffee maker was immediately removed from service and with non-commercial coffee makers were obtained to provide coffee for residents over the weekend, until a new machine could be delivered from the local vendor. All residents were assessed for the ability to manage hot liquids, with care plans updated as needed. He reported that upon observation of the injury, Resident #1's Resident Representative (RR) requested the resident be assessed and treated at an acute care facility, which was reported to the resident's primary healthcare provider with new orders noted for transport via ambulance to local acute care hospital. The Administrator confirmed that the mandatory In-Service Training was provided on 9/04/24 and 9/05/24 for all nursing and dietary staff related to resident safety with hot liquids and introduction of the proposed changes in the Hot Liquids Policy and was attended by one hundred percent (100%) of the required personnel. The Administrator stated that following discovery of Resident #1's injury, he reviewed the resident's Hot Liquids Evaluation dated 6/17/24, in which Resident #1 was determined to be able to manage hot liquids independently. The evaluation was repeated on 9/03/24, revealed the resident was unsafe for hot liquids. He reported that Hot Liquid Evaluations were conducted for all residents on 9/03/24 with care plans updated as needed. He reported that a case conference with QAPI committee members on 9/05/24 during which the facility's Hot Liquids Policy was reviewed, which resulted in an update of the policy to include measurement of coffee temperatures prior to serving to residents and that the temperature of coffee served must not exceed one hundred forty (140) degrees	M 640		

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M 640	Continued From page 5 Fahrenheit when served to resident's at risk for burns from hot liquids. Record review of the Face Sheet for Resident #1 revealed the facility admitted the resident on 3/12/21. The resident had diagnoses that included Vascular Dementia, Type 2 Diabetes, Peripheral Vascular Disease, and Acquired Absence of Right and Left Legs Above the Knee. Record review of the Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) 8/26/24 for Resident #1 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. Further MDS review revealed the resident had no impairment of his functional range of motion of upper extremities and required supervision for eating. Validation: The SA validated on 9/12/24, through interview and record review that all corrective actions had been implemented as of 9/5/24, prior to the SA entrance on 9/11/24.	M 640		