STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255300	A. BUILDING _____ B. WING _____	11/07/2024

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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 11/4/24 through 11/7/24. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F656, F693, F760 and F880. The facility had a census of 78 and was licensed for 88 beds.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		12/4/24

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

Electronically Signed | 11/22/2024

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F 656	Continued From page 1 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record reviews, and facility policy review, the facility failed to ensure the comprehensive care plan interventions were implemented during Percutaneous Endoscopic Gastrostomy (PEG) tube care for one (1) of 19 care plans reviewed. Resident #30 Findings Include: A review of the facility's policy titled "Care Plans," dated 02/20/20 revealed, "Each resident will have a person-centered plan of care to identify problems, needs, and strengths that will identify how the interdisciplinary team will provides care ... PROCEDURE: ... 6. Staff approaches are to developed for each problem/strength/need. Assigned disciplines will be identified to carry out	F 656	A Review and in-service of Resident #30 Comprehensive Care Plan for elevating bed / cleaning percutaneous endoscopic gastronomy (PEG) site was reviewed with Licensed Practical Nurse (LPN) #1 by Consulting Registered Nurse (RN) on 11/6/2024. Resident #30 head was immediately elevated, and peg site dressing reapplied according to plan of care by Director of Nursing (DON). An audit of 78 residents on 11/6/2024 determined only 1 resident (Resident #30) to have a peg tube and to be affected. On 11/11/2024, Contracted RN consultant will conduct an in-service for all nursing staff on importance of following Resident	

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F 656	Continued From page 2 the intervention ..." A record review of Resident #30's "Comprehensive Care Plan" with a start date of 4/4/2019 revealed "Adequate fluid/nutritional intake ...Intervention ...Keep head of bed elevated at all times ...Cleaning peg site with normal saline. Pat the site dry with gauze ...for skin protection." On 11/06/24 at 1:25 PM, during an observation of PEG site care, Licensed Practical Nurse (LPN) #1 lowered the head of the bed to a flat position while the pump continued to infuse the feeding. After cleaning the PEG site, LPN #1 did not dry the PEG tube site prior to applying the split gauze dressing. During an interview with LPN #1 on 11/06/24 at 1:35 PM, she acknowledged that she did not follow the care plan for Resident #30 when she lowered the bed of Resident #30 while the feeding continued to infuse and did not dry the PEG site before applying the split gauze dressing. On 11/07/24 at 12:48 PM, during an interview with the Director of Nursing (DON), she stated that she expects staff to follow the care plan when providing care. On 11/07/24 at 3:00 PM, during an interview with LPN #2, the Minimum Data Set (MDS)/Care Plan Nurse, she explained that staff are expected to adhere to the plan of care, as the purpose of the care plan is to guide the staff in providing appropriate care. A record review of the "Admission Record" revealed the facility admitted Resident #30 on	F 656	Comprehensive Care Plan and specifically Peg site care and Elevating Head of Bed during Nutritional Intake and properly stopping intake and lowering head of bed during dressing change. Staff Development Nurse will continue to in-service all newly hired nurses on following care plan regarding PEG sit care and Elevating head of bed during Nutritional Intake. Quality Assurance Performance Improvement (QAPI) Team consisting of Medical Director, Administrator, Director of Nursing, Infection Preventionists, Social Services, Business Office Manager, Minimum Data Set Nurse, Activity Director, Maintenance Director and Dietary Manager met on 11/11/2024 to review Resident #30 Comprehensive Care Plan and Policy and Procedure for Cleaning / Care of PEG site and Elevating Head of Bed during Fluid/Nutritional Intake and properly stopping intake and lowering head of bed during dressing change and determined no changes to be made. QAPI Team assigned DON and Infection Preventionist to conduct 2 audits per week beginning 11/11/24 for 24 weeks on ability to understand and follow comprehensive care plan for cleaning and replacing PEG site dressing and elevating head of bed during fluid/nutritional intake with tailored competency checkoff form. Results of these audits will be recorded and reported weekly at High Risk beginning on 11/14/2024. Any findings will be corrected and immediately reported to QAPI Team. Director of Nursing will report	

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F 656	Continued From page 3 03/22/19. The resident had diagnoses that included Dysphagia, Oropharyngeal Phase and Encounter for Attention to Gastrostomy. A record review of Resident #30's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/16/24 revealed a Brief Interview for Mental Status (BIMS) score of ninety-nine (99), indicating severely impaired cognition. Section K was coded for PEG tube usage.	F 656	monthly audit results of weekly audits during monthly QAPI Meeting for six months to monitor continued compliance beginning 12/4/2024.	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record	F 693	On 11/6/2024 Resident #30 head was	12/4/24

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F 693	Continued From page 4 reviews, and facility policy review, the facility failed to ensure the physician orders were followed related to the care of a resident with a Percutaneous Endoscopic Gastrostomy (PEG) tube for one (1) of (19) sampled residents. Resident #30. Findings Include: A review of the facility's policy titled, "Dressing Change," policy (undated) revealed, "A dressing change will be done to promote wound healing, prevent infection and to provide an opportunity for wound assessment." On 11/06/24 at 1:25 PM, during an observation of PEG tube site care, Licensed Practical Nurse (LPN) #1 lowered the head of the bed to a flat position while Resident #30's feeding pump was infusing Glucerna 1.2 at 50 cubic centimeters (cc) per hour. LPN #1 then proceeded to clean the PEG site with gauze in a circular motion without drying the site afterward. On 11/06/24 at 1:35 PM, during an interview with LPN #1 , she admitted she forgot to place the feeding pump on hold before positioning the bed flat to conduct care. She acknowledged that she should have dried the site before applying a split gauze. During an interview on 11/07/24 at 12:48 PM, the Director of Nursing (DON), stated that LPN #1 should have stopped the pump. She explained that Resident #30 could aspirate if the pump continues infusing while the bed is flat. She also noted that failing to dry the site could increase the risk of infection.	F 693	immediately elevated, and percutaneous endoscopic gastronomy (PEG) site dressing reapplied according to facility policy and procedure and Physician□s Order by Director of Nursing (DON). A Review and in-service of Physician□s Order and facility policy titled Dressing Change elevating bed / cleaning peg site was reviewed with Licensed Practical Nurse (LPN) #1 by Consulting Registered Nurse (RN) on 11/6/2024. An audit of 78 residents on 11/6/2024 determined only 1 resident (Resident #30) to have a peg tube and to be affected. On 11/11/2024, Contracted RN consultant will conduct an in-service for all nursing staff on importance of following Physician□s Order and Facility Policy and Procedure pertaining to PEG site care - Dressing Change and elevating bed / cleaning peg site. Staff Development Nurse will continue to in-service all newly hired nurses on following physician orders and facility policy and procedure regarding PEG sit care and Elevating head of bed during Nutritional Intake. Quality Assurance Performance Improvement (QAPI) Team consisting of Medical Director, Administrator, Director of Nursing, Infection Preventionists, Social Services, Business Office Manager, Minimum Data Set Nurse, Activity Director, Maintenance Director and Dietary Manager met on 11/11/2024 to review Resident #30 Physician□s Order and Policy and Procedure for Cleaning / Care of PEG site and Elevating Head of	

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F 693	Continued From page 5 A record review of the "Admission Record" revealed the facility admitted Resident #30 on 03/22/19. The resident had diagnoses that included Dysphagia, Oropharyngeal Phase and Encounter for Attention to Gastrostomy. A record review of the "Order Summary Report," revealed Resident #30 had active orders as of 11/07/24 that included an order dated 1/13/24 to keep the head of the bed elevated 30-90 degrees while tube feeding was infusing and an order dated 1/31/24 to clean the PEG site with normal saline, and pat dry with gauze before applying a split gauze to the PEG site daily for skin protection. A record review of Resident #30's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/16/24 revealed a Brief Interview for Mental Status (BIMS) score of (99), indicating severely impaired cognition. Section K was coded for PEG tube use.	F 693	Bed during Fluid/Nutritional Intake and did not determine any changes to be made. QAPI Team assigned DON and Infection Preventionist to conduct 2 audits per week beginning 11/11/24 for 12 weeks for determine, comprehend, and follow physician's order and facility policy and procedure for properly cleaning PEG site dressing and properly stopping intake and lowering head of bed during dressing change using a tailored competency checkoff. Results of these audits will be recorded and reported weekly at High Risk beginning on 11/14/2024. Any findings will be corrected and immediately reported to QAPI Team. Director of Nursing will report monthly audit results of weekly audits during monthly QAPI Meeting for six months to monitor continued compliance beginning 12/4/2024	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to prevent significant medication errors for one (1) of six (6) residents observed for medication administration. Resident #9 Findings Include:	F 760	On 11/7/2024, Director of Nursing (DON) determined that Resident #9 received proper medications according to Physician□s Orders and that improper medication was properly destroyed by Licensed Practical Nurse (LPN) #3 and LPN #6. DON then pulled LPN #3 from cart to conduct an in-service on facility	12/4/24

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F 760	Continued From page 6 A review of the facility's policy titled "Medication Administration Guidelines," (undated), revealed, "Medications are administered as prescribed ...18. Prior to administration, the medication and dosage schedule on the resident's MAR/TAR or EMAR/ETAR is compared with the medication label. Information on the medication should be checked against the MAR/ETAR at least three times during the med preparation and administration process ..." During an observation on 11/04/24 at 8:35 AM, Licensed Practical Nurse (LPN) #3 pulled medications for Resident #9. While pulling medications for an order of Lorazepam Oral Tablet 0.5 mg (milligram) that was to be given once daily for Anxiety Disorder, LPN #3 instead pulled a tablet for Alprazolam 1 mg, 1.5 tablets (to equal 1.5 mg) to be given at bedtime. This medication was placed into the medication cup with the resident's other medications to be administered. LPN #3 confirmed she intended to administer the medication to Resident # 9. The State Agency (SA) questioned whether the Alprazolam medication was due at that time and LPN #3 confirmed that the medication was not due and verified it as the incorrect medication for that time. LPN #3 called LPN #5, and together, they wasted the medication. During an interview on 11/07/24, the Director of Nursing (DON) stated that her expectation was for staff to ensure residents receive the correct medications as prescribed. She emphasized that administering incorrect medications, especially narcotics, could result in adverse outcomes, including lethargy or oversedation, and expressed concern regarding the observed error.	F 760	policy entitled Medication Administration Guidelines prior to administering further medications. LPN #3 voluntarily left employment at that time and did not administer medications following isolated event. A review of 78 residents was conducted by Medical Records Nurse on 11/7/2024 and determined that 0 residents received an improper medication. On 11/11/2024, Contracted RN consultant will conduct an in-service for all nursing staff on importance of following Physician□s Order and Facility Policy and Procedure for Medication Administration Guidelines. Staff Development Nurse will continue to in-service all newly hired nurses on Medication Administration Guidelines prior to medication administration. Quality Assurance Performance Improvement (QAPI) Team consisting of Medical Director, Administrator, Director of Nursing, Infection Preventionists, Social Services, Business Office Manager, Minimum Data Set Nurse, Activity Director, Maintenance Director and Dietary Manager met on 11/11/2024 to review Resident #9 Order Summary and Policy and Procedure for Medication Administration Guidelines and did not determine any changes to be made. QAPI Team assigned DON and Staff Development Nurse to conduct 3 Medication Administration audits per week for a period of 24 weeks beginning	

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F 760	Continued From page 7 A record review of the "Admission Record" revealed the facility admitted Resident #9 on 01/21/15. The resident had diagnoses that included Anxiety Disorder, Depression, and Insomnia. A record review of the "Order Summary Report," with active orders as of 11/07/24 revealed Resident #9 and order for the Lorazepam Oral Tablet 0.5 mg (to be given once daily for Anxiety Disorder, unspecified), with an order start date of 10/02/24 and Alprazolam 1 mg, with an order for 1.5 tablets (to equal 1.5 mg) to be given at bedtime, with an order start date of 10/01/24.	F 760	11/11/24. Results of these audits will be recorded and reported weekly by Staff Development Nurse at High Risk Meeting beginning on 11/14/2024. Any findings while conducting these audits will be immediately corrected and reported to QAPI Team. Staff Development Nurse will report monthly audit results of weekly audits during monthly QAPI Meeting for six months to monitor continued compliance beginning 12/4/2024.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following	F 880		12/4/24

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F 880	Continued From page 8 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 9 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure proper infection control practices were implemented during Percutaneous Endoscopic Gastrostomy (PEG) tube site care and wound care for two (2) of (19) sampled residents. Residents #14 and #30 Findings Include: A review of the facility's policy titled "Hand Hygiene," dated 06/12/22 revealed, "All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors ... If your task requires gloves, perform hand hygiene prior to donning gloves, and sanitize or wash hands after removing gloves ..." Resident #14 On 11/06/24 at 1:08 PM, during an observation of wound care, Licensed Practical Nurse (LPN) #1/Wound Care Nurse, performed a dressing change on Resident #14's right elbow. After removing the soiled dressing from the resident's arm, she placed it on the resident's bedside table without using a barrier and did not use a red biohazard bag for disposal. LPN #1 then proceeded to apply a new dressing without removing her soiled gloves.	F 880	On 11/6/24 Director of Nursing (DON) performed a proper sanitation to Resident #14 right elbow and properly disposed of previous dressing in red biohazard bag. Upon sanitizing hands properly, a new dressing was applied to Resident #14 right elbow. On 11/6/2024 DON entered Resident #30 room following proper sanitation of hands. DON confirmed Head of Bed to be at proper elevation for Nutritional Intake. Upon stopping intake properly, resident head of bed was lowered. DON provided proper removal of previous dressing, cleaning of percutaneous endoscopic gastronomy (PEG) site and application of new dressing according to facility infection control guidelines and cleaning / care of PEG site. On 11/6/2024, Infection Preventionist in-serviced Licensed Practical Nurse (LPN) #1 on facility policy for Infection Control/Prevention pertaining to Care/Cleaning of PEG site, Wound Care, Hand Hygiene, Disposal of Soiled Supplies. A Review of 78 Residents was conducted on 11/6/2024 by Infection Preventionist and determined only 2 residents to be affected. On 11/11/2024, Contracted RN consultant will conduct an in-service for all nursing	

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F 880	Continued From page 10 On 11/06/24 at 1:10 PM, LPN #1 admitted that she did not use a barrier or a red biohazard bag for the soiled dressing, acknowledging failure to do so could lead to infection. During an interview with the Infection Preventionist on 11/07/24 at 9:55 AM, she stated that all staff are expected to follow infection control guidelines, including using appropriate containers for disposing of soiled dressings to prevent the spread of infection. During an interview on 11/07/24 at 10:00 AM, the Director of Nursing (DON) emphasized her expectation that staff adhere to infection prevention protocols when performing wound care. She stated that failure to change gloves or using clean surfaces for soiled dressing could increase the risk of the spread of infection. A record review of Resident #14's "Admission Record" revealed the facility admitted the resident on 07/16/24. The resident had diagnoses that included Dementia, and Pressure Ulcer of Right elbow, Stage 3. Resident #30 On 11/06/24 at 1:25 PM, during an observation of LPN #1 providing PEG tube site care for Resident #30 revealed LPN #1 entered the room without washing her hands or using hand sanitizer. She held one pair of clear gloves upon entry and did not perform hand hygiene before donning the gloves. After lowering the head of the bed with her bare hands, she applied gloves, removed the soiled split gauze from the PEG site, placed it in a red bag, and cleaned the site with gauze and normal saline and applied a new split gauze to	F 880	staff and certified nursing assistants on the importance of following Facility Policy and Procedure for Infection Control/Prevention pertaining to Care/Cleaning of PEG site, Wound Care, Hand Hygiene, Disposal of Soiled Supplies. Staff Development Nurse will continue to in-service all newly hired nurses and Certified Nursing Assistants on Infection Control/Prevention pertaining to Care/Cleaning of PEG site, Wound Care, Hand Hygiene, Disposal of Soiled Supplies.Quality Assurance Performance Improvement (QAPI) Team consisting of Medical Director, Administrator, Director of Nursing, Infection Preventionists, Social Services, Business Office Manager, Minimum Data Set Nurse, Activity Director, Maintenance Director and Dietary Manager met on 11/11/2024 to review Facility Policy and Procedure for Infection Control/Prevention pertaining to Care/Cleaning of PEG site, Wound Care, Hand Hygiene, Disposal of Soiled Supplies and did not determine any changes to be made. QAPI Team assigned Staff Development Nurse and Infection Preventionist to conduct 2 audits per week for 24 weeks beginning on 11/11/2024 using observation and competency checkoffs for ability to follow facility policy and procedure for Infection Control/Prevention pertaining to Care/Cleaning of PEG site, Wound Care, Hand Hygiene, Disposal of Soiled Supplies. Results of these audits will be recorded and reported weekly by Infection Preventionist at High Risk	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255300	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 11 the site. During the procedure, she did not wash her hands, use hand sanitizer, or change gloves. During an interview with LPN #1 at 1:35 PM on 11/06/24, she admitted that she failed to wash her hands or use hand sanitizer upon entering the room and acknowledged she should have performed hand hygiene and changed gloves at different stages of the care. She recognized that her actions could lead to cross-contamination and infection. At 12:48 PM on 11/06/24, the DON confirmed that LPN #1 should have performed hand hygiene before and during the procedure. The DON noted that failure to follow these infection control protocols could lead to the spread of infection. A record review of the "Admission Record" revealed the facility admitted Resident #30 on 03/22/19. The resident had diagnoses that included Dysphagia, Oropharyngeal Phase and Encounter for Attention to Gastrostomy.	F 880	beginning on 11/14/2024. Any findings will be corrected and immediately reported to QAPI Team. Director of Nursing will report monthly audit results of weekly audits during monthly QAPI Meeting for six months to monitor continued compliance beginning 12/4/2024	