

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255300		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/27/2025	
NAME OF PROVIDER OR SUPPLIER WILLOW CREEK RETIREMENT CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 49 WILLOW CREEK LANE BYRAM, MS, BYRAM, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted Complaint Investigations (CIs), MS #487081, MS #487099, MS #487098, and MS #2564771, at the facility from 8/25/25 through 8/27/25. MS #487081 was investigated for the facility's proposed transition of a resident from the Dementia Care Unit to the long-term care unit without clear explanation or consideration of the resident's rights and level of care needs. MS #487099 was investigated for the facility's failure to provide appropriate incontinence care when residents were reported to be placed on sheets and towels instead of bed pads. MS #487098 was investigated for the facility's failure to provide adequate care when a resident was reported to have developed bed sores, fell from a lift resulting in a dislocated shoulder, and required surgery. MS #2564771 was investigated for the facility's failure to ensure proper care and follow-up when a resident was reportedly dropped from a lift causing a dislocated shoulder, left in severe pain, and re-injured during care, as well as allegations of delayed medical attention, inappropriate antibiotic use, and ignored complaints. During the survey, the SA determined the facility was in compliance with the requirements of participation in Medicare and Medicaid and there were no deficiencies cited. The facility held a license for 88 beds, with a census of 85.			F0000			

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 reverse for further 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.

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