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 01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK RETIREMENT CENTER	**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 two (2) Complaint Investigations (CI MS #2704690 and CI MS #2703004) at the facility from 1/05/26 through 1/06/26. Both the CI MS #2704690 and FRI #2703004 were investigated related to dementia care. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cite F740. The facility held a license for 88 beds, with a census of 83 residents.	F0000		
F0740 SS = E	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview and facility policy review the facility failed to provide necessary behavioral services by qualified staff to ensure residents' dignity, privacy, and safety and failed to promote mental and psychosocial well-being for five (5) of (5) residents. Resident #1, Resident #2, Resident #3, Resident #4 and Resident #5. Findings include: Record review of the Facility Policy titled, "Dementia Care" with an implementation date of 1/04/26 revealed, "It is the policy of this facility to provide the appropriate treatment and services to every resident who displays signs of or is diagnosed with dementia, to	F0740		

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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F0740 SS = E	Continued from page 1 meet his or her highest practicable physical, mental and psychosocial well-being…4. Care and services will be person-centered and reflect each resident's individual goals while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice and safety. 5. Individualized, non-pharmacological approaches will be utilized, to include meaningful activities aimed at enhancing the resident's well-being." Resident #1 Record review of the Progress Notes and Incident Report for Resident #1 revealed: On 10/27/25 at 1:15 AM, Resident #1 entered the room of Resident #2 and Resident #5 and got into bed with one of the residents and yelled at her. He pushed her in her bed to the middle of the room and hit and growled at staff and was transferred to the emergency room. On 11/05/25 Nurse Practitioner (NP) #1 visited Resident #1 related to emergency room transfer on 10/27/25 for agitation and aggressiveness. He returned to the facility on 11/04/25 and had an unwitnessed fall in the early morning hours of 11/05/25. The NP noted a plan that included "ongoing monitoring". On 11/10/25 at 11:40 AM, Resident #1 was in Room D10A where there was an incident between him and Resident #4. (Incident Report) On 11/21/25 at 6:16 PM, Resident #1 punched an unnamed staff member at the nursing station. On 12/19/25 at 7:04 AM, Resident #1 went to sleep in another resident's room. On 12/24/25 at 7:43 PM, Resident #1 required frequent redirecting due to going into other resident's rooms. On 12/25/25 at 3:45 AM, Resident #1 removed personal items from a female resident's room and at 4:22 AM Resident #1 was asleep on a couch in a different female resident's room. On 12/25/25 at 7:08 AM, Resident #1 was described as aggressive and hostile and "physically attacked another resident and threatened staff. The NP was notified with new orders noted to transfer the resident out of the facility for assessment and treatment related to behavior. The female resident yelled at him to "get out of her things" and there was an incident between the two residents.	F0740		

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F0740 SS = E	Continued from page 2 On 12/26/25 at 6:25 PM, Resident #1 was on one-on-one supervision and noted lying in another resident's bed following failed attempt at redirection and becoming agitated, yelling profanities and attempting to kick staff. On 12/26/25 at 7:02 PM, Resident #1 took another resident's walker and started pushing into a chair next to its owner, he then urinated in the hallway. On 12/29/25 at 4:40 PM, Resident #1 attempted to get other residents' food. On 1/05/25 at 4:31 PM, Resident #1 urinated in another resident's room on a chair. Resident #1 Record review of the "Admission Record" for Resident #1 revealed the facility admitted the resident on 6/03/25 with diagnoses that included Pick's Disease, Alzheimer's Disease, anxiety and history of falling. Record review of the Admission Minimum Data Set (MDS) for Resident #1 with an Assessment Reference Date (ARD) of 12/17/25 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. MDS review revealed Resident #1 was assessed as able to walk independently indoors. Record review of the physician orders for Resident #1 revealed the resident had order for "Monitor for the following behaviors…restlessness, agitation, hitting biting, kicking, spitting, foul language, elopement, stealing…aggression…every shift" with a start date of 12/11/25 and "Observe closely for significant side effects of Anti-Depressant medication including…unusual changes in mood or behavior…every shift" with a start date of 12/11/25. Resident #2 Record review of the Progress Note for Resident #2 with an effective date of 12/25/25 at 6:30 AM revealed "following incident with another resident, Resident was shaken up originally but was able to calm down." Record review of the Progress Note for Resident #2 dated 12/30/25 at 3:55 PM the DON contacted the resident's Resident Representative (RR) regarding condition and no bodily injuries.	F0740		

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F0740 SS = E	Continued from page 3 Record review of the "Admission Record" for Resident #2 revealed the resident was admitted on 12/05/24 and the resident had diagnoses of Alzheimer's Disease, depression and difficulty in walking and falling and restlessness and agitation. Record review of the Annual MDS with an ARD of 12/08/25 for Resident #2 revealed the resident had a BIMS score of 6, which indicated severe cognitive impairment. The MDS review revealed Resident #2 was independent with walking. Resident #3 Record review of the Progress Note for Resident #3 dated 12/24/25 at 2:29 PM, revealed Resident #3 had a fall during intrusion of another resident as her daughter called for assistance with removing the other resident. Record review of the "Admission Record" for Resident #3 revealed the facility admitted the resident on 5/02/23 and the resident had diagnoses of Alzheimer's Disease, hemiplegia and hemiparesis following cerebral infarction (stroke) affection left non-dominant side and difficulty walking. Record review of the Quarterly MDS with an ARD of 10/20/25 for Resident #3 revealed Resident #3 had a BIMS score of 3, which indicated severe cognitive impairment. The MDS review revealed the resident used a walker or wheelchair and required partial/moderate assistance for walking. Resident #4 Record review of the Progress Note for Resident #4 dated 11/11/25 at 12:59 AM revealed documentation of an incident between her and Resident #1 in her room. Record review of the "Admission Record" for Resident #4 revealed the facility admitted the resident on 8/05/16 and the resident had diagnoses of dementia, need for assistance with personal care, and depression. Record review of the Quarterly MDS with ARD 10/17/25 for Resident #4 revealed the resident had a BIMS score of 13, which indicated no cognitive impairment. The MDS review revealed Resident #4 was able to walk without assistance. Resident #5 Record review of the Admission Record for Resident #5	F0740		

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F0740 SS = E	Continued from page 4 revealed the facility admitted the resident on 8/19/25 and the resident had diagnoses of Alzheimer's Disease, history of falling. Record review of the Quarterly MDS with an ARD of 11/24/25 for Resident #5 revealed the resident had a BIMS score of 3, which indicated severe cognitive impairment. The MDS review revealed the facility assessed Resident #5 used a walker or wheelchair. On 1/05/25 at 10:00 AM, telephone interview with the Complainant for CI#2704690 revealed she visited the dementia unit at the facility regularly as a visitor and had observed staff give Resident #1 time and space to keep him calm, including allowing him to wander or stay in other residents' rooms, but that approach had not worked at all. She stated that during a visit she observed Resident #1 get into Resident #5's bed while she was not in the room. Complainant states she feared what would have happened if Resident #5 had been in her bed in her room. She stated she was not sure if a linen changed was accomplished before Resident #5 got into her bed. The Complainant said that on 12/24/25 she visited Resident #3 and observed the resident and her daughter go into the bathroom and was waiting in the bedroom for them to come out of the bathroom when Resident #1 begin to come to the room and she got her foot behind the room door and held the door closed so he could not enter the room as he continued pushing against the door and she kept telling him he needed to go to his room, that was not his room. The Complainant stated at the time resident pushed with force to open the door all the way, even as she tried to hold it as Resident #3's daughter was bringing her from the bathroom into the room, and they (Resident #3 and her daughter) stepped back into the bathroom to pull the red emergency cord for staff to come. She stated that Resident #1 refused to leave the room and was becoming increasingly agitated. The Complainant stated she was not sure if Resident #3 was frightened or off balance due to change of course, but she fell to the floor of the bathroom while Resident #1 was in the room going towards the bathroom. The Complainant confirmed that staff did respond to the red call light and were able to redirect him to leave Resident #3's room. The Complainant confirmed she was leaving one-night last week, and a female resident (she did not know the resident's name) was in the hall and summoned to her to come to her room and when she looked in the room, Resident #1 was "in the lady's room, and the resident was terrified and would not go into her room due to it". The Complainant confirmed she had observed Resident #1 enter the common dining room for a meal and reach for food items from other resident's	F0740		

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F0740 SS = E	Continued from page 5 trays/plates. On 1/05/25 at 12:35 PM, during an interview the Administrator confirmed that he was familiar with Resident #1 and his care. He confirmed that all incidents were reviewed by the Interdisciplinary Team (IDT) with review of the resident's care plan. He confirmed that nursing staff were responsible for providing adequate supervision for residents and included "strategically placed staff and keeping hallway lights on during the evening hours". He confirmed that, while wandering and disorientation were common symptoms of dementia, it was the responsibility of staff to ensure safe wandering and provide a sense of safety and security for all residents. On 1/05/26 at 2:00 PM, during an interview with Certified Nursing Assistant (CNA) #1 stated she had picked up an extra shift on the night shift on or around 11/10/25. While answering Resident #4's call light, Resident #4 was standing at her bedside and Resident #1 was exiting her bathroom door. She stated that she attempted to redirect Resident #1 to exit the room, but he walked toward Resident #4 instead and the residents' hands bumped. She stated that the nurse came into the room and assessed both residents and Resident #1 was sent out via ambulance for assessment and treatment due to wandering and difficulty with redirection. She said that all the residents on the Dementia Unit went into and out of each other's rooms. She stated she was aware that care instructions for Resident #1 included supervision and monitoring for safe wandering. On 1/05/26 at 3:00 PM, an interview with Social Services Director, (SSD) she confirmed that the facility IDT discussed issues with the residents' behaviors during morning meetings Monday through Friday to determine root cause of adverse or aggressive behaviors and resultant interventions to provide for the physical, mental, emotional and psychosocial well-being of all residents. On 1/05/25 at 4:47 PM, a telephone interview with the RR for Resident #1 revealed she was concerned about the amount of supervision provided considering several and repeated incidents involving Resident #1, specifically on the evening/night shift. She stated that Resident #1 had "sundowning", which is frequently associated with dementia and could result in increased confusion and disorientation during evening/night hours. On 1/06/26 at 12:50 PM, an interview with the Assistant Director of Nursing (ADON) revealed she was responsible	F0740		

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F0740 SS = E	Continued from page 6 for providing in-service training for nursing staff. She stated that In-Service Training was provided for nursing staff monthly. She stated that In-Service Training for nursing staff on the dementia unit included environmental accommodations that the evening hours the hallway lights should remain on and there should be a staff member positioned at the “end” of the hallway “to provide full coverage” of the hall, which she confirmed meant that all resident room doors and the entire hall would be in view of the staff. She confirmed she was on duty on the Dementia Unit on 12/25/25 as the direct care nurse for all residents including Resident #1 on the 3:00 PM to 11:00 PM and stayed over as direct care provider from 11:00 PM to 7:00 AM. She explained that the resident returned to the facility from a local acute care hospital where he had been transferred because of an episode of wandering during which Resident #1 had entered the room of Resident #2. She stated that the Administrator had instructed staff to place Resident #1 on one-on-one (1:1) for (24) hours on 12/26/25 through 12/27/25. She confirmed Resident #1 attempted to take food items from other residents as she documented on 12/29/25. On 1/06/25 at 3:50 PM, during an interview the Director of Nurses (DON) confirmed that one of the main focuses for a resident that was ambulatory and had wandering behaviors and dementia was “to have eyes on them” and provide the level of assistance and supervision needed by each resident. She stated staff were trained to intervene if a resident attempted to enter another resident’s room uninvited, invaded their privacy or take their belongings. She stated that it was the responsibility of the staff to ensure residents in the dementia unit had a safe, homelike environment with their belongings, and provided a sense of safety and security. She stated that adequate staffing and supervision for residents in the dementia unit was very important ant that they required “close monitoring”. The DON confirmed that the IDT reviewed all incidents, attempted to determine root cause analysis and nonpharmacologic interventions to decrease aggressive and disruptive behaviors, therefore she was aware of the repeated incidents of interactions between Resident #1 and other residents on the dementia unit. She stated that staff were aware that Resident #1 had behavior of wandering into other residents’ rooms resulting in incidents between himself and other residents, urinating in their rooms, and taking their belongings. She confirmed she expected nursing staff to provide adequate supervision, monitoring and interventions to ensure the highest practicable well-being for all residents and report to her if there were any problems or need for additional assistance. The DON identified	F0740		

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F0740 SS = E	Continued from page 7 individualized, non-pharmacological interventions to attain or maintain the resident's well-being for Resident #1 could include, but had not been incorporated, confirmation that the residents television and electronic drum set were operating correctly for activities and entertainment, provide radio (or television capability) for music for the resident, work with resident and family regarding visual aides to help the resident identify his room and bathroom.	F0740		