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 _____	C 05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK RETIREMENT CENTER	**49 WILLOW CREEK LANE JACKSON, 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 a complaint survey from 05/11/21 through 05/14/21 for Complaint Investigations (CI) # 17790 for Abuse (Certified Nurse Assistant (CNA) #1 applied liquid soap in Resident #1 eyes and face was substantiated and SA cited F600 for physical abuse for Resident #1. The following complaints were investigated and were not substantiated: CI #17547 for Neglect related Monitoring Resident's and Medication Not Given, CI #17530 related to Infection Control for skin issues, CI # 17511 related to Neglect for failure to monitor residents and Quality of Care (QOC) Resident Safety/Falls and No Contact with Administration, CI #17545 QOC related to services not performed per plan of care and QOC related to resident not groomed, and CI #16816 Abuse related to CNA was verbally abusive to a resident. The census at the time of the surrey was 82, and the facility held a license for 88 beds.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or	F 600		7/20/21

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

Electronically Signed | 07/19/2021

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F 600	Continued From page 1 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review, the facility failed to ensure one (1) resident was free from physical abuse related to a staff member placing soap in the eyes of a resident for one (1) of four (4) residents reviewed for physical abuse, Resident #1. Findings include: Review of the facility's," Abuse Program" policy, revised May 23, 2017, revealed, "It is the policy of this facility to take all steps necessary to maintain an environment free of abuse and neglect. Each resident has the right to be from... physical... abuse... The facility is committed to protecting the residents from abuse by anyone including, facility staff..." Record review of the incident report "Reportable Incident Report" dated 05/07/21, revealed Resident #1 was often combative when being bathed. On 5/4/21, a shower was required on Resident #1 due to feces on multiple areas of her body. Resident #1 was brought to the shower room on a shower gurney. Soothing music was played for Resident #1. The nurses were bathing Resident #1, when Certified Nursing Assistant (CNA) #1 poured liquid soap all over Resident #1's body, including her face and head. CNA #1 was observed to be laughing while pouring the soap on Resident #1. Resident #1 became upset telling them the soap was burning her eyes and was agitated. License Practical Nurse (LPN) #2 and LPN #1 assisted Resident #1 in getting the soap out of Resident #1's eyes and informed CNA #1 to leave the shower room. Registered	F 600	" Resident # 1 suffered no lasting adverse effects from this deficient practice. Certified Nursing Assistant #1 was immediately removed from the shower room and instructed to leave the facility. Licensed Practical Nurse #1 and Licensed Practical Nurse #2 immediately washed the soap from Resident #1□s eyes, face, and body. An assessment of the resident was done by LPN #1 and LPN #2 on May 4, 2021, and no injuries to the resident was noted. On 5/5/2021, Certified Nursing Assistant #1 was terminated by Administrator. " All residents needing assistance with bathing are at risk from this deficient practice. " On 5/5/2021 at 830am, an in-service was conducted with staff by Staff Development Nurse on Abuse and Neglect. This incident was discussed in a Quality Assurance Meeting on May 5, 2021, with the Administrator, Director of Nursing, the Medical Director, Staff Development Nurse, Medical Records Nurse, Social Services, Activities Director, and MDS nurse. The Abuse and Neglect Policy was reviewed and there were no policy changes needed. New employees are educated on the Abuse and Neglect Policy on hire by Staff Development. The Social Worker will interview three interviewable residents a week for four weeks then, two interviewable residents a week for four weeks to determine if any resident has been a victim of abuse or	

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F 600	Continued From page 2 Nurse (RN) #1 entered the shower room and witnessed CNA #1 in the shower room with a gallon of soap in her hands. RN #1 informed CNA #1 to leave the facility immediately. RN #1 notified the Administrator and Director of Nurses (DON) immediately. The Administrator notified the Resident Representative (RR), State Agency (SA), Attorney General, and the physician. An investigation was initiated. Following the investigation, CNA #1 was terminated 05/05/21. On 05/11/21 at 3:30 PM, SA attempted to interview Resident #1. Resident #1 was awake with her eyes open but unable to communicate with the SA. On 5/11/21 at 3:45 PM, in an interview with the Administrator, revealed Resident #1 required a bath because she had a bowel movement and smeared stool all over her body. LPN #1, LPN #2, and CNA #2 assisted with Resident #1's bath, when CNA #1 poured almost a gallon of liquid soap on Resident's body, face, and hair, while giggling. The Administrator reported the injury to the SA, Attorney General, RR, and Physician immediately. The facility immediately escorted CNA #1 out of the facility. CNA #1 was placed on suspension until the investigation was completed. Following the investigation, CNA #1 was terminated, and the facility performed Abuse/Neglect in-services with all staff. Resident #1's care plan was updated, and the incident was discussed in Quality Assurance (QA). On 5/11/21 at 4:00 PM, in an interview with RN #1 revealed she was present in the facility when she heard a loud noise coming from the shower room. When investigated, she observed CNA #1 standing at the head of Resident #1's shower	F 600	neglect or if they have witnessed any other resident being abused or neglected beginning July 20, 2021.This will be monitored through the review of in-service sign in sheets monthly for six months by the administrator or the Director of Nursing. The Director of Nursing will interview two interviewable residents for eight weeks to ensure compliance beginning July 19, 2021. Any adverse findings will be presented to the Quality Assurance Committee immediately by the Administrator for corrective action.	

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F 600	Continued From page 3	F 600		

area. Staff who were present during Resident #1's bath revealed CNA #1 was pouring liquid soap on Resident #1's body, head, and face while laughing. RN #1 escorted CNA #1 out of the building until an investigation was completed. RN #1 immediately notified the Administrator and DON.

On 5/11/21 at 4:45 PM, attempted to call CNA #1 for a telephone interview but did not get an answer. A detailed voice mail was left to return the call to the SA.

On 5/11/21 at 4:45 PM, in an interview with LPN #1 revealed, Resident #1 had a bowel movement and had stool all over her body, nails, and hair. LPN #1 received assistance from LPN #2, CNA #2, and CNA #1. Staff was aiding with bath, but CNA #1 used almost a gallon of liquid soap on Resident #1 spreading it on her body, face, and hair, then she just started laughing out loud for no apparent reason. LPN #2 asked CNA #1 to leave the shower room because her actions where not appropriate and Resident #1 had soap in her eyes, and her eyes were burning.

On 5/12/21 at 9:30 AM, in an interview with the Social Worker (SW) #1 revealed if the facility has an abuse allegation, she observes and interviews cognitive residents several days after to make sure there is no mental anguish. If the resident has a low Brief Interview for Mental Status (BIMS) score, then she observes and interviews nurses/RR to ascertain if there are any mental problems after the incident. SW #1 revealed there was no mental anguish following the abuse allegation to Resident #1 and no change of behavior.

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F 600	Continued From page 4	F 600		

On 05/12/21 at 2:30 PM, in an interview with LPN #2, revealed when assisting staff with bath for Resident #1, CNA #1 was observed pouring liquid soap all over resident's body, face, and hair while laughing. LPN #2 immediately told CNA #1 to leave the bathing room. CNA #1 was making Resident #1 upset.

On 05/12/21 at 4:00 PM, in an interview with CNA #2, revealed she was assisting staff perform a bath on Resident #1. She witnessed CNA #1 poured a bottle of soap on Resident #1's body, hair, face, and laughed when it started burning Resident #1's eyes.

Record review of the Face Sheet revealed Resident #1 was admitted on 10/14/15 with the diagnoses of Bipolar Disorder, Dementia, and Hypertension.

Record review of Resident #1's Quarterly Comprehensive Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 03/3/21 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 99, which indicated she was not interviewable. Review of Resident #1's MDS Section F 0120 bathing revealed a score of four (4) indicating total dependence with bathing.

Review of nurses notes on 05/05/21 at 11:39 AM revealed, "Resident #1 have swelling, redness and watery eyes." Physician notified with new orders to give Zyrtec 10 milligrams (MG) one time a day for five (5) days and Artificial Tears three (3) to four (4) drops to both eyes three times a day for five (5) days.

Record review of a physician order dated 05/05/2,

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F 600	Continued From page 5 revealed Zyrtec 10 milligrams (MG) one time a day for five (5) days and Artificial Tears three (3) to four ((4) drops to both eyes three times a day for five (5) days.	F 600		