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 _____	11/16/2017

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 Survey Agency (SA) conducted an annual recertification survey at the facility from 11/13/17 to 11/16/17. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited the regulatory deficiency F441. At the time of survey, the census was 84 and the facility held a license for 88 beds.	F 000		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (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: (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 §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (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	F 441		12/11/17

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

Electronically Signed | 12/05/2017

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F 441	Continued From page 1 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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their	F 441		

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F 441	Continued From page 2 program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to administer medication in a manner to prevent cross contamination for one (1) of seven (7) medication administrations observed, Resident #12; and, failed to perform accuchecks in a manner to prevent cross contamination for one (1) of three (3) accuchecks performed, Resident #11. Findings include: Resident #12 A review of the facility's "Infection Control Policy" noted: All employees are required to wash their hands after each direct contact for which hand washing is indicated by acceptable professional practice. A review of the facility's "Hand Washing"policy, noted: Staff will use proper hand washing technique to prevent the spread of infection. On 11/13/17 at 3:47 PM, Licensed Practical Nurse (LPN) #1 prepared and administered medication to Resident #12 and did not wash his hands prior to giving the medication. On 11/13/17 at 4.00 PM, LPN #1 prepared and performed an accucheck procedure on Resident #11, without washing or sanitizing his hands before or after the procedure. On 11/13/17 at 4:45 PM, interview with LPN #1, revealed he did not wash his hands before or after giving medication to Resident #12 nor before or after performing the accucheck on	F 441	Residents #11 and #12 were assessed by Director of Nursing on 11/13/17 there were no adverse outcomes related to the deficient practice. Residents #11 and #12 currently receiving glucose monitoring and medications per policy and procedure in a manner to decrease infection. LPN#1 was counseled,inserviced and checked off on proper hand washing, glucometer disinfection and infection control per policy, procedure and practice guidelines by the Director of Nursing on 11/14/17. The facility has determined that all residents that receive medications and that all diabetics in the facility that require finger stick glucose monitoring have the potential to be affected by this deficient practice. All licensed nursing staff were in-serviced on the facilities glucometer disinfection policy and practice guideline, hand washing and infection control policy and procedures by the Director of Nursing. In-service training included observation of each nurse performing glucometer disinfection and hand washing. A validation check list was completed for each nurse to determine if the nurse was performing the procedure correctly. Findings will be reviewed with each nurse and corrective action provided as needed. All in-services completed by 12/5/17. The director of Nursing or Staff	

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F 441	Continued From page 3 Resident #11. LPN #1 stated he should have washed his hands because of cross-contamination. On 11/16/17 at 9:10 AM, interview with Director of Nursing (DON), revealed LPN #1 should have washed his hands in between going into different resident rooms. The DON also stated that handwashing prevents the spread of infection, and was also the facility policy. A review of the facility's Face Sheet revealed the facility admitted Resident #12 on 11/4/16, with diagnoses of Major Depressive Disorder and Dementia. A review of Resident #12's most recent quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/04/17, revealed a Brief Interview for Mental Status (BIMS) score of 07, which indicated a severe cognitive impairment. A review of Resident #11's face sheet revealed the facility admitted the resident on 9/22/17, with diagnoses which included Major Depressive Disorder and Symbolic Dysfunction. A review of Resident #11's most recent MDS with an ARD of 10/25/17, revealed a BIMS score of 7, which indicated severe cognitive impairment.	F 441	Development will complete validation checklist three times a week for one month then twice weekly for two weeks of nurses performing glucometer disinfection and hand washing procedure in accordance with our facility's policies and procedures, physician's order and care plan. Validation checklist will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee at monthly quality Assurance/Risk Management committee meetings.	

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	255300	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2017**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to provide a supervised automatic sprinkler system with complete coverage for all portions of the building. This deficiency practice affected one (1) of five (5) smoke compartments and zero (0) residents in the building at the time of survey.	K 351	FIRE SAFETY Received DEC 18 2017 MSDH-HFLC & CONSTRUCTION 12-18-17 Accepted Revisit Maintenance Supervisor was in-serviced on 11/16/17 on sprinkler regulation by corporate maintenance director. Vendor contacted to install sprinklers on 11/16/17. Received proposal on install from vendor on 11/21/17.	12/11/17

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K 351	Continued From page 1 Findings include: On 11-16-17 at 1:40 PM, observations revealed no sprinkler coverage in a large, gas fueled Mechanical Room located in the Housekeeping Storage of the facility. The Mechanical Room supplied air conditioning and heat to the Kitchen Area of the facility. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor during the exit interview on 11-16-17.	K 351	Facility determined that 20 residents had the potential to be affected by this deficiency. Sprinklers were installed on 12/1/17 per an outside vendor. Maintenance supervisor or designee will monitor new sprinklers weekly for 6 weeks, any problems noted will be reported to vendor for immediate repairs. Vendor will continue quarterly inspections of sprinkler system. Monitoring and inspection documentation will be reviewed by the Quality Assurance Committee monthly to ensure substantial compliance.	