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 03/27/2018

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, MS 15096, from 3/26/18 through 3/27/18. During the survey the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements for Participation. The SA cited deficiencies at F600 and F656. The facility held a license for beds with a census of 88, and the census was 84 on the day of survey.	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 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy/procedure review, the facility failed to provide goods and services necessary to avoid physical harm, pain, mental anguish or emotional distress, resulting in neglect, to one (1) of five (5) residents reviewed, Resident #1, as evidenced by	F 600	Immediate action(s) taken for the resident found to have been affected include: Resident #1□'s injury to her right eye was evaluated by the Licensed Practical Nurse on 3/18/18 and immediately reported to	4/26/18

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

Electronically Signed | 04/24/2018

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 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.

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 03/27/2018

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 600	Continued From page 1 Certified Nurse Aide (CNA) #1 attempted a pivot transfer of Resident #1 from her bed to her wheelchair. Resident #1's Lift/Transfer assessment revealed she required a Sit to Stand lift transfer with the assist of two (2) staff members. Resident #1 fell during the pivot transfer, and hit her head on her armrest of the wheelchair. CNA #1 did not report the incident to anyone. Findings include: Policy/procedure review of the facility's "Abuse Program" with a revision date of May 23, 2017, revealed the definition of Neglect is "the failure of the facility, its employees or services providers to provide goods and services necessary to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional stress." Policy/procedure review of the facility's "Modified Lifting Policy", with a revision date 5/29/15, revealed: "The facility will provide a safe work environment coordinator for the facility Nursing employees will receive mechanical lift training at orientation, annually or as needed." The Procedure revealed: "1. Staff will follow the documented lifting protocol deemed appropriate for each resident. This information is documented in the smart charting and via a sticker system which is located on each lift for reference to each resident." Review of the "Care Plans" policy, not dated, revealed the CNA Daily Care Guide or Pocket Care Guide is part of the Comprehensive Care Plan and used as the tool to make staff aware of the resident's daily care needs.	F 600	Registered Nurse #1 to verify the location and extent of injury. Registered Nurse #1 began an investigation and notified the Medical Doctor with orders to begin neuro checks and monitor Resident #1. The resident□s sponsor was notified promptly upon completion of the assessment. A thorough investigation was initiated by the Director of Nursing Services and the facility Administrator. The facility terminated Certified nursing assistant #1 on 3/19/18 due to failure to follow Resident #1□'s care plan for transfer and failure to report resident #1's actual fall and hitting her head on the wheelchair armrest. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service education program was conducted on 3/19/18, 3/26/18 and 4/4/18 by the Staff Development Nurse on Abuse Program and Reporting Abuse and Neglect Policy and Procedures with all direct care staff addressing circumstances that require reporting including appropriate timeframes. All newly hired staff will be inserviced during orientation and as needed. An in-service education program was conducted on 3/20/18, 3/23/18, 3/26/18,	

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 03/27/2018

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 600	Continued From page 2 Record review revealed that Resident #1 was admitted to the facility on 6/8/17, with the diagnosis of Dementia in other diseases without behavior disturbances. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/2/18, revealed she had a Brief Interview for Mental Status (BIMS) of 1, which indicated severe cognitive impairment. Review of the most recent, "Resident Lift/Transfer Assessment", dated 3/2/18, revealed Resident #1 required a "Sit to Stand Lift" with the assist of two (2) staff members. Record review of the facility investigation, revealed on 3/18/18 at approximately 7:15 AM, Resident #1 was sitting in her wheelchair in the dayroom. It was noted by Licensed Practical Nurse (LPN) #1 that Resident #1 had a knot on her forehead above her right eye with bruising across the bridge of her nose and around her right eye. A ruptured blood vessel in the inner corner of her right eye and the left eye was slightly swollen and had a small amount of redness around it. Registered Nurse #1 was notified and began an investigation. The Medical Doctor (MD) was notified with orders to begin neurochecks and monitor Resident #1. The facility's investigation revealed that CNA #1 attempted a pivot transfer on Resident #1 on 3/18/18 at 6:00 AM, and Resident #1 fell during the transfer and hit her face on the wheelchair armrest. Resident #1's most recent Lift and Transfer Assessment revealed that she was assessed for a Sit to Stand lift for transfers with two (2) staff members to assist. CNA #1's shift ended and she left the facility without alerting a nurse to the incident. CNA #1 admitted to not using a lift to transfer the resident and that she	F 600	3/29/18 and 4/4/18 by the Staff Development Nurse on the Lift Program, Care Plan, and Direct Care Guide care plan policy and procedures with all direct care staff. All newly hired nursing staff will be inserviced during orientation and as needed. All Direct Care Staff were checked off on use of the Lifts by Staff Development on 3/20/18 through 4/19/18. A 100 percent audit was completed on lift assessments on 3/26/18 and 4/23/18 by MDS Coordinator to ensure the accuracy of type of lift required for each resident. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services, or Registered nurse will conduct an audit of five (5) residents weekly for four (4) consecutive weeks. These residents will be assessed and interviewed to ensure that any injuries are identified, properly investigated and reported to the appropriate authorities. Findings of this audit will be discussed with the Administrator. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. The Director of Nursing Services, or Staff Development nurse will conduct a lift check off of five (5) residents weekly for four (4) consecutive weeks. These residents will be monitored to ensure the correct lift is properly used according to the lift assessments and care plans.	

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 03/27/2018

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 600	Continued From page 3 attempted the transfer without the assist of another staff member, after it was brought to her attention there was video of her going into the resident's room without a lift. The facility suspended Certified Nurse Aide (CNA) #1, and then terminated her employment, after completion of the investigation, due to the CNA's failure of following Resident #1's care plan for transfer. Review of the Daily Care Guide, used by CNAs for Assistance of Daily Living (ADL) activity, revealed Resident #1 required a sit to stand lift, medium sling, with two (2) person assist for all transfers. Interview with CNA #1, on 3/26/18 at 10:00 AM, revealed she admitted she did not use a lift when she transferred Resident #1, she didn't know why. She said it was not the first time she had done this type of transfer with Resident #1. She stated, "I was standing her up out of bed. Her wheelchair was there, she fell and her head hit the arm of her wheelchair." She said she didn't tell anyone about the incident, "because she didn't look hurt". She stated, "I was told to get a nurse if there is a fall." CNA #1 stated, "I would ask the other CNA's what to do with my residents". She then gave the name of a CNA that no longer works at facility saying that she had helped that CNA do a pivot transfer on Resident #1. CNA #1 acknowledged that she did not look in the Kiosk (for the care plan) to find out how to transfer Resident #1. CNA #1 stated she did not know the care plans were behind the nurse's desk for the residents. CNA #1 acknowledged that knew Resident #1 required a two (2) person, mechanical lift transfer and did not use the lift.	F 600	Validation check offs performed by the certified nursing assistances will be discussed with the Administrator. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	

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 03/27/2018

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 600	Continued From page 4 Interview with the CNA Supervisor, on 3/26/18 at 10:17 AM, revealed she trained the CNAs on how to use the lifts and the guides that show which lift the resident required. The CNA Supervisor stated that when using the Kiosk, the CNA will see the lift type and sling size, right beside where they chart for ADLs. Interview with Licensed Practical Nurse #1, on 3/27/18 at 10:50 AM, revealed she saw the bruising beginning to show on Resident #1's forehead and a knot above her right eye not long after she came to work on 3/18/18. The resident was in her wheelchair in the dayroom. She stated she came in at approximately 6:50 AM. Interview with Registered Nurse #1, on 3/27/18 at 12:15 PM, revealed she began the investigation and contacted the Nurse Practitioner for orders. Neurochecks were ordered and she did not want to do any X-rays. She said the resident did not complain of pain when the area was palpated and neurochecks were normal. She stated she did an interview with CNA #1 during the investigation, and CNA #1 denied the resident hit her head and did not know what happened. Interview with the Administrator on 3/26/18 at 8:00 AM, revealed she watched the video from the hallway camera regarding the incident with Resident #1 on 3/18/18. The Administrator stated that CNA #1 never took a lift into Resident #1's room on 3/18/18, and upon questioning, CNA #1 admitted to transferring the resident without the lift and without another staff member. The Administrator stated that CNA #1 never told anyone that Resident #1 had fallen and hit her face/head against the wheelchair.	F 600		

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 03/27/2018

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 600	Continued From page 5 Interview with CNA #2, on 3/26/18 at 10:30 AM, revealed CNAs are trained on hire where to find each resident's care information. CNA #2 stated the information is in the Kiosk and in a book behind the nurse's station. She stated that there was a chart that revealed which lift is used for which resident. Record review revealed CNA #1 received training on both the neglect and lift policies on 9/30/16. A more recent in-service, dated 6/7/17, revealed CNA #1 was trained on examples of abuse/neglect, with an example of not having two (2) people to assist with transferring the resident being an example of neglect. Documentation revealed CNA #1 had training on Electronic (E)-charting (smart charting) on 9/30/16. Review of the job description, signed by CNA #1 on 9/30/16, revealed part of the job responsibility was to properly use lifting equipment.	F 600		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		4/26/18

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 03/27/2018

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 656	Continued From page 6 (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 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. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and policy/procedure review, the facility failed to implement a care plan for one (1) of five (5) residents reviewed, Resident #1, as evidenced by Certified Nurse Aide (CNA) #1 failed to follow the CNA Activities of Daily Living Care Plan and attempted a pivot transfer of Resident #1 from her bed to her wheelchair. Resident #1's Lift/Transfer assessment, and ADL care plan, revealed she required a Sit to Stand transfer with the assist of two (2) staff members. Resident #1 fell during the pivot transfer and hit her head on	F 656	1.Immediate action(s) taken for the resident(s) found to have been affected include: Care plan of Resident #1 was reviewed and updated as indicated on 3/19/18 by MDS Coordinator. The Staff Development nurse monitored the lift/transfer procedure on Resident #1 on 3/19/18 to ensure the correct lift was utilized and nursing staff had implemented the Activities of Daily Care plan/Daily Care Guide and found no negative outcomes. The facility terminated	

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 03/27/2018

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 656	Continued From page 7 the armrest of her wheelchair. Findings include: Policy/procedure review revealed the facility's policy for Care Plans revealed "Each resident will have a plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care". "CNA Daily Care Guide or Pocket Care Guide-part of the Comprehensive Care Plan and used as the tool to make staff aware of the resident's daily care needs." Review of Resident #1's ADL Care Plan and Daily Care Guide (which is the CNA Care Plan) revealed she required a Sit to Stand lift for transfers with two (2) staff members to assist. Record review revealed that Resident #1 was admitted to the facility on 6/8/17, with the diagnosis of Dementia in other diseases without behavior disturbances. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/2/18, revealed she had a Brief Interview for Mental Status (BIMS) of 1, which indicated severe cognitive impairment and unable to make her own decisions. The most recent, "Resident Lift/Transfer Assessment", dated 3/2/18, revealed the resident required a "Sit to Stand Lift" with the assist of two (2) staff members. Record review, of the 3/18/18 facility investigation, revealed on 3/18/18 at approximately 7:15 am, Resident # one (1) was sitting in her wheelchair in the dayroom. It was noted by Licensed Practical Nurse (LPN) #1 that	F 656	Certified nursing assistant #1 on 3/19/18 due to failure to follow Resident #1□s care plan for transfer and failure to report resident #1□s actual fall and hitting her head on the wheelchair armrest. 2.Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3.Actions taken/systems put into place to reduce the risk of future occurrence include: All scheduled nursing staff were inserviced and reeducated on the facility□s policy and procedure for implementing the Comprehensive Care Plans and Activities of Daily Care plan/Daily Care Guide and following the Lift/Transfer policy and procedure on 3/20/18, 3/23/18, 3/26/18, 3/29/18 and 4/4/18 by Staff Development Nurse. Newly hired nursing staff will be trained and checked off on Lift/Transfers and following the Lift and Transfer and Activities of Daily Living Care Plan/Daily Care Guide during orientation and as needed. The Director of Nurses and Minimum Data Set nurses audited 100 percent of Lift/Transfer care plans on 3/26/18 and 4/23/18 to ensure correct lifts were care planned. The Staff Development nurse monitored the lift/transfer procedure on Resident #1 on 3/19/18 to ensure the correct lift was	

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 03/27/2018

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 656	Continued From page 8 Resident #1 had a knot on her forehead above her right eye with bruising starting to appear across the bridge of her nose and around her eye. A ruptured blood vessel in the inner corner of her right eye and the left eye was slightly swollen and had a small amount of redness around it. Registered Nurse #1 was notified and began an investigation. The Medical Doctor (MD) was notified with orders to begin neurochecks and monitor Resident #1. The investigation revealed that the facility suspended CNA #1, then terminated her employment after completion of the investigation. Their investigation revealed that CNA #1 attempted a pivot transfer on Resident #1 and Resident #1 fell during the transfer, hitting her head on the wheelchair armrest. Resident #1's most recent Lift and Transfer Assessment revealed that she was assessed for a Sit to Stand lift for transfers, with two (2) staff members to assist. CNA #1's shift ended and she left the facility without alerting a nurse to the incident. CNA #1 admitted to not using a lift to transfer the resident and that she attempted the transfer without the assist of another staff member after it was brought to her attention there was video of her going into the resident's room without a lift. An interview with CNA #3, the CNA supervisor, on 3/26/18 at 10:17 AM, revealed she trained the CNA's on how to use the lifts. "When using the Kiosk, the CNA will see the lift type and sling size. It is right beside where they chart they used that lift and chart their ADL's". An interview with CNA #1 on 3/26/18 at 10:00 AM, confirmed she did not followed the care plan for Resident #1. CNA #1 stated she didn't know where the care plans on the Kiosk were located and she didn't know they were behind the nurse's	F 656	utilized and nursing staff had implemented the Activities of Daily Care plan/Daily Care Guide and found no negative outcomes. 4.How the corrective action(s) will be monitored to ensure the practice will not recur: Care plans will be reviewed weekly in accordance with the care plan review schedule by the Minimum Data Set nurse Coordinator. All care plans will be updated as indicated. The Director of Nursing Services or Registered Nurse Supervisor will complete (5) care plan audits on residents with lifts for four (4) consecutive weeks to ensure that comprehensive care plans are developed and implemented for these residents. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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 03/27/2018

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 656	Continued From page 9 desk. CNA #1 confirmed she attempted to transfer Resident #1 without assistance and without a lift and the resident fell and hit her head on the armrest of the wheelchair. She confirmed she didn't tell anyone about the incident, because she thought the resident wasn't hurt. Review of facility documentation revealed CNA #1 was trained on Electronic (E)-charting (Kiosk) on 9/30/16. Review of the job description, signed by CNA #1 on 9/30/16, revealed part of the job responsibility was to properly use lifting equipment.	F 656		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25WC	A. BUILDING: _____ B. WING _____	C 03/27/2018

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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a complaint survey, MS 15096, at the facility 3/26/18 through 3/27/18. During the survey, the SA determined the facility was not in compliance with State Licensure Regulations for the Aged or Infirm, and cited State Statute M500.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance	M 500		4/26/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25WC	A. BUILDING: _____ B. WING _____	C 03/27/2018

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) COMPLETE DATE
M 500	Continued From page 1 with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;	M 500		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25WC	A. BUILDING: _____ B. WING _____	C 03/27/2018

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) COMPLETE DATE
M 500	Continued From page 2 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25WC	A. BUILDING: _____ B. WING _____	C 03/27/2018

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) COMPLETE DATE
M 500	Continued From page 3 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on record review, interview, and policy/procedure review, the facility failed to provide goods and services necessary to avoid physical harm, pain, mental anguish or emotional distress, resulting in neglect, and a violation of resident rights, for one (1) of five (5) residents reviewed, Resident #1, as evidenced by Certified Nurse Aide (CNA) #1 attempted a pivot transfer	M 500	1.Immediate action(s) taken for the resident found to have been affected include: Resident #1's injury to her right eye was evaluated by the Licensed Practical Nurse on 3/18/18 and immediately reported to Registered Nurse #1 to verify the location and extent of injury. Registered Nurse #1 began an investigation and notified the Medical Doctor with orders to begin neuro	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25WC	A. BUILDING: _____ B. WING _____	C 03/27/2018

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) COMPLETE DATE
M 500	Continued From page 4 of Resident #1 from her bed to her wheelchair. Resident #1's Lift/Transfer assessment revealed she required a Sit to Stand lift transfer with the assist of two (2) staff members. Resident #1 fell during the pivot transfer, and hit her head on her armrest of the wheelchair. CNA #1 did not report the incident to anyone. Findings include: Policy/procedure review of the facility's "Abuse Program" with a revision date of May 23, 2017, revealed the definition of Neglect is "the failure of the facility, its employees or services providers to provide goods and services necessary to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional stress." Policy/procedure review of the facility's "Modified Lifting Policy", with a revision date 5/29/15, revealed: "The facility will provide a safe work environment coordinator for the facility Nursing employees will receive mechanical lift training at orientation, annually or as needed." The Procedure revealed: "1. Staff will follow the documented lifting protocol deemed appropriate for each resident. This information is documented in the smart charting and via a sticker system which is located on each lift for reference to each resident." Review of the "Care Plans" policy, not dated, revealed the CNA Daily Care Guide or Pocket Care Guide is part of the Comprehensive Care Plan and used as the tool to make staff aware of the resident's daily care needs. Record review revealed that Resident #1 was admitted to the facility on 6/8/17, with the diagnosis of Dementia in other diseases without	M 500	checks and monitor Resident #1. The resident□s sponsor was notified promptly upon completion of the assessment. A thorough investigation was initiated by the Director of Nursing Services and the facility Administrator. The facility terminated Certified nursing assistant #1 on 3/19/18 due to failure to follow Resident #1□s care plan for transfer and failure to report resident #1□s actual fall and hitting her head on the wheelchair armrest. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service education program was conducted on 3/19/18, 3/26/18 and 4/4/18 by the Staff Development Nurse on Resident□s Rights Policy and Procedures with all direct care staff. All newly hired staff will be inserviced during orientation and as needed. An in-service education program was conducted on 3/19/18, 3/26/18 and 4/4/18 by the Staff Development Nurse on Abuse Program and Reporting Abuse and Neglect Policy and Procedures with all direct care staff addressing circumstances that require reporting including appropriate timeframes. All newly hired staff will be inserviced during orientation and as needed. An in-service education program was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25WC	A. BUILDING: _____ B. WING _____	C 03/27/2018

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) COMPLETE DATE
M 500	Continued From page 5 behavior disturbances. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/2/18, revealed she had a Brief Interview for Mental Status (BIMS) of 1, which indicated severe cognitive impairment. Review of the most recent, "Resident Lift/Transfer Assessment", dated 3/2/18, revealed Resident #1 required a "Sit to Stand Lift" with the assist of two (2) staff members. Record review of the facility investigation, revealed on 3/18/18 at approximately 7:15 AM, Resident #1 was sitting in her wheelchair in the dayroom. It was noted by Licensed Practical Nurse (LPN) #1 that Resident #1 had a knot on her forehead above her right eye with bruising across the bridge of her nose and around her right eye. A ruptured blood vessel in the inner corner of her right eye and the left eye was slightly swollen and had a small amount of redness around it. Registered Nurse #1 was notified and began an investigation. The Medical Doctor (MD) was notified with orders to begin neurochecks and monitor Resident #1. The facility's investigation revealed that CNA #1 attempted a pivot transfer on Resident #1 on 3/18/18 at 6:00 AM, and Resident #1 fell during the transfer and hit her face on the wheelchair armrest. Resident #1's most recent Lift and Transfer Assessment revealed that she was assessed for a Sit to Stand lift for transfers with two (2) staff members to assist. CNA #1's shift ended and she left the facility without alerting a nurse to the incident. CNA #1 admitted to not using a lift to transfer the resident and that she attempted the transfer without the assist of another staff member, after it was brought to her attention there was video of her going into the resident's room without a lift. The facility	M 500	conducted on 3/20/18, 3/23/18, 3/26/18, and 3/29/18 and 4/4/18 by the Staff Development Nurse on the Lift Program, Care Plan, and Direct Care Guide care plan policy and procedures with all direct care staff. All newly hired nursing staff will be inserviced during orientation and as needed. All Direct Care Staff were checked off on use of the Lifts by Staff Development Nurse on 3/20/18 through 4/19/18. A 100 percent audit was completed on lift assessments on 3/26/18 and 4/23/18 by MDS Coordinator to ensure the accuracy of type of lift required for each resident. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services, or Registered nurse will conduct an audit of five (5) residents weekly for four (4) consecutive weeks. These residents will be assessed and interviewed to ensure that any injuries are identified, properly investigated and reported to the appropriate authorities. Findings of this audit will be discussed with the Administrator. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. The Director of Nursing Services, or Staff Development nurse will conduct a lift check off of five (5) residents weekly for four (4) consecutive weeks. These residents will be monitored to ensure the correct lift is properly used according to the lift assessments and care plans.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25WC	A. BUILDING: _____ B. WING _____	C 03/27/2018

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) COMPLETE DATE
M 500	Continued From page 6 suspended Certified Nurse Aide (CNA) #1, and then terminated her employment, after completion of the investigation, due to the CNA's failure of following Resident #1's care plan for transfer. Review of the Daily Care Guide, used by CNAs for Assistance of Daily Living (ADL) activity, revealed Resident #1 required a sit to stand lift, medium sling, with two (2) person assist for all transfers. Interview with CNA #1, on 3/26/18 at 10:00 AM, revealed she admitted she did not use a lift when she transferred Resident #1, she didn't know why. She said it was not the first time she had done this type of transfer with Resident #1. She stated, "I was standing her up out of bed. Her wheelchair was there, she fell and her head hit the arm of her wheelchair." She said she didn't tell anyone about the incident, "because she didn't look hurt". She stated, "I was told to get a nurse if there is a fall." CNA #1 stated, "I would ask the other CNA's what to do with my residents". She then gave the name of a CNA that no longer works at facility saying that she had helped that CNA do a pivot transfer on Resident #1. CNA #1 acknowledged that she did not look in the Kiosk (for the care plan) to find out how to transfer Resident #1. CNA #1 stated she did not know the care plans were behind the nurse's desk for the residents. CNA #1 acknowledged that knew Resident #1 required a two (2) person, mechanical lift transfer and did not use the lift. Interview with the CNA Supervisor, on 3/26/18 at 10:17 AM, revealed she trained the CNAs on how to use the lifts and the guides that show which lift the resident required. The CNA Supervisor stated that when using the Kiosk, the CNA will see the	M 500	Validation check offs performed by the certified nursing assistances will be discussed with the Administrator. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25WC	A. BUILDING: _____ B. WING _____	C 03/27/2018

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) COMPLETE DATE
M 500	Continued From page 7 lift type and sling size, right beside where they chart for ADLs. Interview with Licensed Practical Nurse #1, on 3/27/18 at 10:50 AM, revealed she saw the bruising beginning to show on Resident #1's forehead and a knot above her right eye not long after she came to work on 3/18/18. The resident was in her wheelchair in the dayroom. She stated she came in at approximately 6:50 AM. Interview with Registered Nurse #1, on 3/27/18 at 12:15 PM, revealed she began the investigation and contacted the Nurse Practitioner for orders. Neurochecks were ordered and she did not want to do any X-rays. She said the resident did not complain of pain when the area was palpated and neurochecks were normal. She stated she did an interview with CNA #1 during the investigation, and CNA #1 denied the resident hit her head and did not know what happened. Interview with the Administrator on 3/26/18 at 8:00 AM, revealed she watched the video from the hallway camera regarding the incident with Resident #1 on 3/18/18. The Administrator stated that CNA #1 never took a lift into Resident #1's room on 3/18/18, and upon questioning, CNA #1 admitted to transferring the resident without the lift and without another staff member. The Administrator stated that CNA #1 never told anyone that Resident #1 had fallen and hit her face/head against the wheelchair. Interview with CNA #2, on 3/26/18 at 10:30 AM, revealed CNAs are trained on hire where to find each resident's care information. CNA #2 stated the information is in the Kiosk and in a book behind the nurse's station. She stated that there was a chart that revealed which lift is used for	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25WC	A. BUILDING: _____ B. WING _____	C 03/27/2018

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) COMPLETE DATE
M 500	Continued From page 8 which resident. Record review revealed CNA #1 received training on both the neglect and lift policies on 9/30/16. A more recent in-service, dated 6/7/17, revealed CNA #1 was trained on examples of abuse/neglect, with an example of not having two (2) people to assist with transferring the resident being an example of neglect. Documentation revealed CNA #1 had training on Electronic (E)-charting (smart charting) on 9/30/16. Review of the job description, signed by CNA #1 on 9/30/16, revealed part of the job responsibility was to properly use lifting equipment.	M 500		