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 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK RETIREMENT CENTER	49 WILLOW CREEK LANE BYRAM, 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 Investigation (CI), at the facility for two (2) complaints,CI MS #21937 and CI MS #21963, from 8/10/23 through 8/11/23. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm,state licensure requirements. The SA investigated CI MS #21937 for Resident Abuse and CI MS #21963 for Quality of Care related to resident being left soiled, wet, and not turned for extended periods of time and cited M500. At the time of survey the facility was licensed for 88 beds and had a census of 86 residents.	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	M 500		9/23/23

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M 500	Continued From page 1 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 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,	M 500		

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M 500	Continued From page 2 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; 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;	M 500		

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M 500	Continued From page 3 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); 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	M 500	1. Immediate action(s) taken for	

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M 500	Continued From page 4 Based on interview, record review, policy review, and review of the facility reported incident investigation, the facility failed to ensure residents were free from abuse and neglect for two (2) of four (4) residents reviewed for abuse and neglect. Residents #1 and #2. Findings include: Review of the facility's policy, "Abuse Program", 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 free from verbal, sexual, physical and mental abuse, ...Abuse means the will infliction of injury ...intimidation, or punishment with resulting physical harm, pain, or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that instances of abuse of all residents, irrespective of any mental or physical condition ...cause physical harm, pain or mental anguish. It includes verbal abuse ...and mental abuse ...Willful, as used in the definition of abuse, means the individual must have acted deliberately, not the individual must have intended to inflict injury or harm ...Verbal Abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms ...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. Neglect occurs when facility staff fail to monitor and/or supervise the delivery of resident care and services to assure that care is provided as	M 500	resident(s) found to have been affected include: Certified Nurse's Assistant (CNA) #1 placed on leave pending investigation on 6-19-23. Resident #1 was assessed for negative emotional outcomes post incident by Social Services on 6-19-23. The Administrator completed a thorough investigation of the alleged deficiency; the results were submitted to State Agency on 6-23-23. CNA #1's employment was terminated on 6-23-23. CNA #2 placed on leave pending investigation on 6-26-23. Resident #2 was assessed for skin issues, and the physician was updated on 6-24-23 by the DON. CNA #2's employment was terminated on 6-29-23. The Administrator completed a thorough investigation of the alleged deficiency; the results were submitted to the State Agency on 6-29-23. 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 in place to reduce the risk of future occurrences include: Employees from all departments participated in detailed training covering: Resident Rights Vulnerable Adults Act Vulnerable Adults Reporting and Investigation Process	

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M 500	Continued From page 5 needed by residents. Neglect occurs when a facility fails to provide necessary care for residents, such as situations in which residents are left to lie in urine or feces ..." Resident #1 Record review of the Facility Investigation dated 6/19/23, revealed that on 6/16/23, it was determined that Certified Nurse Aide (CNA) #1 yelled and used derogatory language toward Resident #1 during routine care. On 8/10/23 at 10:00 AM, in an interview with Housekeeper #1, she revealed that on 6/16/23, she was working in the hallway on "B Hall". The Housekeeper confirmed at approximately 10:30 AM, while she was outside the door of Resident #1, she could hear CNA #1 cursing and yelling. The Housekeeper verified that she recognized the voice as that of CNA #1. On 8/11/23 at 11:55 AM, a telephone interview with the former Human Resource (HR) Coordinator revealed that on 6/16/23, CNA #3 had verbally reported that CNA #1 had a "filthy mouth." The former HR Coordinator revealed that CNA #1 had a history of using foul language and had received disciplinary action regarding her inappropriate language prior to 6/16/23. On 8/11/23 at 12:08 PM, in a telephone interview with CNA #3, she revealed that on 6/16/23, she had been assigned to work with CNA #1 for the 6:00 AM to 2:00 PM shift. She stated that at approximately 10:30 AM, she and CNA #1 entered the room of Resident #1, to provide care for the resident. She stated that after CNA #1 explained the procedure (dressing) to the Resident #1, he swung his legs off the bed. CNA	M 500	Abuse, Neglect and Exploitation Policy Employees participating in the training completed post training tests on Resident Abuse Prevention and Reporting. This training is being conducted by Quality Assurance Nurse and is still underway and will be completed by 9-8-23. Staff knowledge of abuse prevention and reporting requirements will be audited by conducting informal interviews of staff. The Human Resources Coordinator (HRC) will interview ten (10) staff from day shift and five (5) staff from evening shift weekly. The Administrator will interview two (2) staff from night shift weekly beginning. These staff interviews began 8-28-23 and will continue weekly through 9-30-23. After which, monthly audits of will then continue for an additional three months (October, November and December) with the results being reported to the QAPI Committee. Monthly audits will involve interviewing 10-day shift employees monthly, 5-evening shift employees monthly and 5-night shift employees monthly. Interviews will be completed by the HRC and Administrator. Weekly residents five (5) residents (approximately 5%) will be interviewed to determine if they feel safe and how they are treated by staff. These interviews will be conducted by Social Services and Activities and the interviews began 8-28-23. 4. How corrective actions will be monitored to ensure the practice will not	

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M 500	Continued From page 6 #1 said the resident had "kicked" her. CNA #3 stated at that time, CNA #1 began to yell at the resident and tell him that she wasn't going to help him anymore. CNA #3 said that CNA #1 got a shirt to dress the resident in and the resident expressed that he did not want to wear that shirt. CNA #3 stated that at that time, CNA #1 "threw the shirt down" and used derogatory language speaking to the resident. She stated that CNA #1 yelled at the resident, "(Expletive) this! I'm not putting up with this today!" CNA #3 reported that Resident #1 then told CNA #1, "You aren't supposed to talk to me that way." CNA #1 revealed during a break at approximately 3:30 PM, she had reported the verbal abuse of Resident #1 by CNA #1, to the former HR Coordinator. Record review of the Face Sheet for Resident #1 revealed the facility admitted the resident on 5/13/22. The resident's current diagnoses included Unspecified Dementia, Type 2 Diabetes Mellitus, Paroxysmal Atrial Fibrillation, and Essential Hypertension. Record review of the Annual Minimum Data Set (MDS) for Resident #1, with Assessment Reference Date (ARD) of 5/15/23, revealed the resident was unable to complete the Brief Interview for Mental Status (BIMS) and received a score of 99. The staff assessment revealed the resident had both a short-term and long-term memory problem and the resident's cognitive skills, for daily decision making, were moderately impaired to poor. Resident #2 Record review of the Facility Investigation dated	M 500	recur: Staff knowledge audit results will be reviewed on 9-1-23, 9-8-23 and 9-15-23 in Stand-up meeting. Audit results will be reviewed by the QAPI Committee on 9-20-23 to determine if substantial compliance has been achieved. Monthly audits of Staff knowledge will then continue for an additional three months (October, November and December) with the results being reported to the QAPI Committee. The Resident Interview results will be reviewed in Stand-up meeting on 9-1-23, 9-8-23 and 9-15-23. Audit results will be reviewed by the QAPI Committee on 9-20-23 to determine if substantial compliance has been achieved. Monthly audits will then continue for an additional three months (October, November and December) with the results being reported to the QAPI Committee.	

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M 500	Continued From page 7 6/29/23, revealed that on 6/24/23, CNA #2 had not entered the room of Resident #2 or provided any type of care for the resident during her shift. The resident had not received incontinence care from 5:46 AM through 2:48 PM on 6/24/23, and was not repositioned, bathed, dressed, or provided with any type of personal hygiene during that time. On 8/10/23 at 11:24 AM, during a telephone interview with the Resident Representative (RR) for Resident #2, she revealed that on 6/24/23, at approximately 2:30 PM, she had visited Resident #2 and observed that the resident and her bed were wet with urine and the resident had a strong odor of urine and feces. She stated the resident's incontinence brief was saturated and the bed sheets were wet with urine, and the resident was soiled. On 8/10/23 at 2:09 PM, during a telephone interview with Licensed Practical Nurse (LPN) #1, she confirmed that on 6/24/23, she had been assigned to care for Resident #2, and to supervise CNA #2 during the 7:00 AM to 7:00 PM shift. The LPN stated she had entered the room of Resident #2 and provided nursing care to the resident at least three (3) times during the day. LPN #1 denied noting that the resident had not been repositioned during that time and had not noted any foul orders. The LPN revealed that later that afternoon, when the family of the Resident #2 went into the room to visit the resident, they requested that LPN #1 step into the resident's room. LPN #1 revealed that it was at that time that she noted a foul odor and discovered that the Resident #2's brief was saturated with urine, as well as her bed sheets. LPN #1 stated that CNA #2 should have made rounds every two (2) hours to reposition the	M 500		

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M 500	Continued From page 8	M 500		

resident and provide incontinent care as needed.

On 8/11/23 at 9:35 AM, during an interview with the Administrator, she confirmed that the facility conducted a thorough investigation and substantiated the allegation of verbal abuse by CNA #1 towards Resident #1 on 6/16/23. During the same interview, the Administrator also confirmed that she had viewed the facility security camera footage from the ceiling mounted camera in the hallway outside the room of Resident #2 and that CNA #2 had not entered the room of Resident #2 during the 6:00 AM shift to 2:00 PM shift on 6/24/23. The Administrator stated that an investigation was conducted which resulted in neglect begin substantiated for Resident #2 on 6/24/23.

On 8/11/23 at 1:25 PM, during a telephone interview with CNA #2, she revealed that on 6/24/23, she "forgot" that she had been assigned to care for Resident #2. She stated, "I forgot to go in there", and confirmed she didn't provide the care to Resident #2 that she was supposed to provide.

Record review of the Facesheet for Resident #2 revealed the resident was admitted by the facility on 3/22/19, and had diagnoses that included Unspecified Dementia, Encounter for Attention to Gastrostomy, and Dysphagia.

Record review of the Quarterly MDS for Resident #2, with an ARD of 7/26/23, revealed that the resident was unable to participate in a BIMS and assessed as having short term and long-term memory problems and the resident's cognitive skills for daily decision making were moderately impaired to poor. The MDS review revealed that Resident #1 required extensive assistance for

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M 500	Continued From page 9 dressing, eating, toilet use and personal hygiene.	M 500		