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 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) COMPLETION DATE
F 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 in not compliance with the requirements for participation in Medicare and Medicaid. The SA investigated CI MS #21937 for Resident Abuse and cited F600. CI MS #21963 for Quality of Care related to resident left wet, soiled and not turned for extended periods of time and cited F600 and F656. At the time of survey the facility was licensed for 88 beds and had a census of 86 residents.	F 000		
F 600 SS=E	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 interview, record review, policy review, and review of the facility reported incident	F 600	1. Immediate action(s) taken for resident(s) found to have been affected	9/23/23

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

Electronically Signed | 08/31/2023

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F 600	Continued From page 1 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 needed by residents. Neglect occurs when a facility fails to provide necessary care for	F 600	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	

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F 600	Continued From page 2 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 #1 said the resident had "kicked" her. CNA #3	F 600	Investigation Process 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.	

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F 600	Continued From page 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	F 600	4. How corrective actions will be monitored to ensure the practice will not 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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F 600	Continued From page 4	F 600		

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

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F 600	Continued From page 5	F 600		

rounds every two (2) hours to reposition the 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

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F 600	Continued From page 6 impaired to poor. The MDS review revealed that Resident #1 required extensive assistance for dressing, eating, toilet use and personal hygiene.	F 600		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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 (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	F 656		9/23/23

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F 656	Continued From page 7 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview, record review, policy review and facility investigation review, the facility failed to ensure that the comprehensive person-centered care plan was implemented for two (2) of four (4) residents reviewed for abuse and neglect. Residents #1 and #2 Findings include: Record review of the facility policy "Care Plans" updated 2/20/2020 revealed, "Policy: Each resident will have a person-centered plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care .... Procedure: ...6. Staff approaches are to be developed for each problem/strength/need. Assigned disciplines will be identified to carry out the intervention. Resident #1 Record review of the Facility Investigation dated 6/19/23, revealed that on 6/16/23, Certified Nurse Aide (CNA) #1 was determined to have yelled and used derogatory language toward Resident	F 656	1. Immediate action(s) taken for resident(s) found to have been affected include: The care plan for Resident #1 was reviewed and updated by Minimum Data Set (MDS) Nurse on 6-22-23. Resident #2's care plan was reviewed and updated by MDS Nurse on 6-27-23. 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: All interdisciplinary care plan team members responsible for writing care plans were educated on the facility's policy and procedure for developing	

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F 656	Continued From page 8 #1 during routine care. Record review of the Care Plan for Resident #1 revealed the resident had a Care Plan with a start date of 5/15/23 " 'Description...Decision making: Impaired Cognitive skills for daily decision making related to Dementia...Intervention...Approach from the front in a calm, unhurried manner...Resident may refuse care...Intervention...Allow opportunity to make choices and participate in care..." Record review of the Facesheet 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) 5/15/23, revealed that the resident was not able to participate in the Brief Interview for Mental Status (BIMS) and was 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. Resident #2 Record review of the Facility Investigation dated 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	F 656	Comprehensive Care Plans on 8-28-23 by MDS nurse. Representatives from Nursing, MDS, Medical Records, Social Services, Dietary and Activities attended a day long training session on Comprehensive Care Planning and the development of care plan interventions. This training was provided off-site by corporate staff on 9-1-23. Certified Nursing Assistant (CNA) and Nursing staff participated in training regarding the role of the "Resident Summary" and how to access that document in order to determine a resident's care needs. This training was completed on 8-30-23 and provided by Quality Assurance Nurse. CNA and Nursing staff will participate in training on How to Deal with Aggressive Residents and those that Resist Care. This training is scheduled to be provided the week of 9-4-23 by the Quality Assurance Nurse. The Resident Summary is used by CNA's to guide the care being provided. This summary is to be completed on admission, updated with any changes, after completion of the risk assessments and quarterly by the Register Nurse (RN) Supervisor. An audit of all Resident Summaries was completed 8-31-23 to identify any missing Resident Summaries and to ensure that special needs were identified. This audit was completed by the Director of Nursing (DON) and RN	

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F 656	Continued From page 9 that time. Record review of the Care Plan for Resident #2 with a start date of 4/04/19, revealed, "Care Plan 'Description Urinary/Bowel Incontinence: Always" ...Intervention: Assist with perineal cleansing as needed ... Provide prompt attention to incontinent episodes. ...Risk for impaired skin integrity related to impaired mobility ...'Intervention ...Turn and reposition every two hours and prn (as needed) ...ADL's Requires assistance for all ADL's ...Intervention... Assist with ADL's as needed, Bathing: Total dependence, one person assist, Toileting: extensive, one person assist, Bed Mobility: extensive one person assist ..." 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 #2 required extensive assistance for dressing, eating, toilet use and personal hygiene. On 8/10/23 at 4:25 PM, during an interview with the Minimum Data Set (MDS) Nurse, she revealed that the MDS Nurse was responsible for the development of an individualized care plan for each resident along with the Dietary Department, Social Worker, and Activity Director. She stated	F 656	Supervisor. Beginning 8-28-23, MDS nurses will perform weekly audits of care plans and resident summaries. All care plans and resident summaries will be updated as indicated. Each week 5% of the charts from each unit will be reviewed (3 charts from Long-term Unit, 1 chart from Rehabilitation Unit and 1 chart from Dementia Unit). The charts reviewed will be pulled from a pool of high-risk residents (i.e., behavioral issues, falls, psychoactive drugs, refusal of daily care). Audits will be completed to ensure that comprehensive care plans have been developed and are current for each resident. Any care plan needs identified will be assigned to the appropriate discipline to resolve. The care plan/resident summary reviews will continue for twelve (12) consecutive weeks ending 11-6-23. 4. How corrective actions will be monitored to ensure the practice will not recur: Audit results will be reviewed in Clinical on 9-1-23, 9-8-23 and 9-15-23. The QAPI Committee will meet on 9-20-23 to determine if substantial compliance has been achieved. The care plan and resident summary audits will continue to be reported and reviewed in the Clinical meeting weekly and monthly to the QAPI Committee	

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F 656	Continued From page 10 that residents were assessed for the level of assistance needed for activities of daily living (ADL), including bed mobility (turning/repositioning in bed), and incontinence care/toilet use. She stated that care plans for residents that required assistance for bed mobility and incontinence care included turning/repositioning and incontinence care provided by nursing staff (CNAs and nurses) every two (2) hours and as needed (PRN). She explained that the care plan interventions were communicated to the CNAs via the "Care Guide" software, available to all CNAs on the facility wall mounted kiosks. On 8/11/23 at 1:39 PM, during an interview the Director of Nurses (DON) stated that residents requiring assistance with toilet use and incontinence should be checked and incontinence care performed at least every two hours. She stated that based on the security camera footage and a thorough investigation which included an interview with CNA #2, Resident #2 had not received incontinence care or turned/repositioned during the 6:00 AM to 2:00 PM shift on 6/24/23. She confirmed that she expected nursing staff provide ADL care for all residents, including but not limited to monitoring for incontinence care needs and turning/repositioning for residents who required assistants at least every two hours, dressing, bathing, and monitoring of skin in accordance with current standards of practice and the residents' individualized care plans. The DON confirmed that the MDS Nurse entered the residents' individualized patient centered care plans into the computer software program which "pulled" the information into the "Care Guide". She said the CNAs were instructed and expected to use the "Care Guide" available to them on the	F 656	through the week of 11-6-23.	

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 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 11 wall mounted kiosks on each hallway as a guide for provision of care in accordance with each resident's care plan. She confirmed that care plans should be implemented/followed as written .	F 656		