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	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Creek Retirement Center	49 Willow Creek Lane Byram, MS 39272

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 42807 Based on observations, record review, interviews, and facility policy review, the facility failed to provide care and services to promote healing and prevent infection for one (1) of four (4) residents that required wound care. Resident #2 Findings Include: Record review of the facility policy titled DRESSING CHANGE, (undated), revealed, A dressing change will be done to promote wound healing, prevent infection and to provide an opportunity for wound assessment. On 5/23/24 at 3:50 PM, an observation of Resident #2 revealed she was lying on her back in bed. The resident's incontinence brief was wet and had fecal matter present. There were two small open areas on her sacral area, with no bandage present. On 5/23/24 at 4:55 PM, an interview with the Assistant Director of Nurses (ADON) revealed she was assigned to the care of Resident #2 on 5/23/24. She stated she had not provided wound care to Resident #2. She explained that she intended to wait because evening meal trays had just been delivered to the hall and she had to assist with meal deliveries. She stated, when trays come out, everyone stops doing what they're doing and passes trays, as she continued to retrieve meal trays from the cart. On 5/23/24 at 5:25 PM, an interview with the ADON revealed that Resident #2 had not yet had wound care to her sacral area on . She confirmed that the resident had not had a dressing in place from 3:50 PM until 5:25 PM. She also confirmed that Resident #2 was always incontinent of bowel and bladder. On 5/24/24 at 5:55 PM, in an interview with the ADON, she revealed Resident #2 received sacral wound care and her sacral dressing had been replaced after 5:30 PM, by Registered Nurse (RN) #1. On 5/24/24 at 2:00 PM, an interview with RN #1 revealed that she had performed wound care for Resident #2 on 5/23/24 after 5:30 PM. She confirmed that the resident had not had a dressing in place at the time, however, she did not know why. The nurse confirmed that it was important for incontinent residents, with open wounds, to have dressings in place according to physician orders to reduce the risk of infection. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/24/24 at 2:10 PM, an interview with Medical Doctor (MD) #1 revealed he it was important for physician orders for dressings to open areas to the sacral area be followed to provide a barrier to prevent exposure to urine and fecal matter in residents that are incontinent of bowel and bladder. He stated that this was important to prevent infection. On 5/24/24 at 2:30 PM an interview with the facility Administrator revealed he expected physician orders for wound care to be carried out in a manner to protect residents' skin and prevent infection. He stated that there was no facility policy in place that stated resident needs could not be provided during meal times. Record review of the Face Sheet for Resident #2 revealed the facility admitted the resident on 2/10/21. The resident had diagnoses of Chronic Kidney disease, Venous Insufficiency, and Stage 2 pressure Ulcer of Sacral Region. Record review of the Physician Orders, dated May 2024, for Resident #2, revealed an order, dated 4/16/24, to Cleanse stage 2 pressure injury to sacrum with normal saline. Pat dry with gauze. Apply foam dressing. Change daily and PRN until healed. Record review of the Electronic Treatment Administration Record (ETAR), for May 2024, revealed RN #1 performed wound care for Resident #2 on 5/23/24.