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	06/04/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility policy review and interviews, the facility failed to ensure that a resident was protected from physical abuse when the Resident Representative (RR) struck the resident in the face. for one (1) of seven (7) sampled residents. (Resident #2).Findings Included:Record review of the facility policy Abuse, Neglect and Exploitation with a revision date 5/25/24, revealed .Mistreatment means inappropriate treatment or exploitation of a resident.Physical Abuse includes, but is not limited to hitting, slapping.It also includes controlling behavior through corporal punishment.The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves.III. Prevention of Abuse. E. Ensuring the health and safety of each resident with regard to visitors such as family members or resident representatives.Record review of the Facility Investigation dated 6/02/26 revealed that on 6/2/26 at approximately 8:30 AM, Certified Nursing Assistant (CNA)# 1 and the RR for Resident #2 was assisting Resident #2 with changing his shirt as he sat in his recliner. Resident #2 became agitated and struck out at CNA #1 and his RR. Resident #2's RR slapped the resident's face two times and told him to stop. CNA #1 went to the nurse and reported the incident, and the RR had left the facility. Resident #2 was assessed by the nurse and Nurse Practitioner (NP)#1 with no injuries noted. On 6/02/26 at 10:30 AM during an interview, the Administrator reported that on 6/2/26 at approximately 8:30 AM, CNA #1 and the RR were assisting Resident #2 to change his shirt. Resident #2 became agitated and began striking out at CNA #1 and the RR. The RR struck Resident #2 on his face twice and told him to Stop it. He stated that he had reported the incident to the local police department, the State Agency (SA) and the State Attorney General's Office.On 6/02/26 at 11:55 AM, during an interview CNA #1 reported that on 6/02/26 at approximately 8:30 AM Resident #1 was seated in a recliner in his room and his RR visited and said that she wanted to help him with his breakfast in the common dining area. CNA #1 stated that she and the RR were trying to assist the resident with dressing (to change his shirt) and he began to strike out at both. She said that she was shocked when the RR struck Resident #2 twice on the face and sternly told him to Stop it. She stated that the resident's behavior changed immediately.On 6/02/26 at 12:30 PM, during an interview, Licensed Practical Nurse (LPN) #1 stated that during breakfast she was assisting/supervising residents in the dining room with breakfast when CNA #1 reported to her that a RR had struck Resident #2 twice while assisting him with dressing. She stated that she immediately assessed Resident #2 who was in the dining room for breakfast and noted no injury then reported the incident to the Director of Nurses (DON) and Administrator.On 6/04/26 at 11:20 AM, during an interview the DON stated that after she had spoken with LPN #1 and CNA #1, she felt Resident #2's RR had struck the resident to control his behavior through corporal measures. On 6/04/26 at 3:00 PM, an interview with the Administrator revealed the facility had completed the investigation into the visitor (RR) on resident abuse allegation that was reported on 6/02/26 and involved Resident #2 and had submitted final report to the SA.On 6/04/26 at 3:04 PM, during a telephone interview the RR for Resident #2 confirmed that her hand contacted the face of Resident #2 at approximately 8:30 AM on 6/02/26 after (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he became combative toward her and CNA #1while they were trying to assist him with dressing. She confirmed that she told him to Stop it and said that afterward he stopped striking out at them and allowed them to assist him to change his shirt. She said she did it to get his attention to get him to stop being combative and cooperate.Record review of the Face Sheet for Resident #2 revealed the resident was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, metabolic encephalopathy and anxiety.Record review of the discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/07/26 revealed Resident #2 had a memory problem and moderately impaired cognitive skills for daily decision making and that he required substantial/maximal assistance for upper body dressing.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on observation, record review, facility policy review and interviews, the facility failed to ensure that residents were free from the misappropriation of resident property and exploitation when a licensed nurse signed for and took scheduled medication delivered by the pharmacy for one (1) of four (4) residents reviewed for medication administration. (Resident #1). Findings Included:Record review of the facility policy, Abuse, Neglect and Exploitation with a revised date of 05/25/24 revealed, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent. Record review of the Facility Investigation dated 4/20/26 revealed that on 4/17/26, Registered Nurse (RN) #1 received for two (2) bubble packages of Tramadol 50 milligram (mg) from the pharmacy courier, failed to log the packages/medication into the Narcotics Accountability form, took the packages/medication out of the facility in her bag/purse and four (4) days later returned one of the packages with (30) tablets in a damaged condition and failed to return the other package of seven (7) tablets.On 6/01/26 at 11:50 AM, an interview with the Administrator revealed that he had been notified by the Director of Nurse's (DON) on 4/21/26 that Resident #1's Tramadol was missing. He stated that he and the DON were able to determine with cooperation with the pharmacy services and review of security camera footage that RN #1 received and signed for delivery of thirty-seven (37) Tramadol packaged in two (2) bubble package cards, placed them on the Back Hall Nurses Station desk (counter top), covered them with papers and later placed both packages in her bag/purse, threw away the pharmacy manifest, which was supposed to be turned into the DON and left the facility with the medication. He said that when the resident requested pain mediation on 4/21/26 the misappropriation was discovered. He said that RN #1 was on duty on 4/21/26 and was taken to her home via the facility van and returned to the facility with one (1) damaged package of thirty (30) Tramadol (verified by pharmacist) but not the remaining package of seven (7). He stated that RN #1 had been immediately placed on suspension upon determination that she was on duty and responsible for the resident's medications at the time of the incident and that her employment at the facility had been terminated for theft of resident property.On 6/04/26 at 11:20 AM, observation and interview with the DON revealed she was on direct care duty on the 3:00 PM through 11:00 PM shift on 4/21/26 when Resident #1 requested pain medication, which led to the discovery that the resident did not have any of her physician ordered Tramadol in the locked scheduled medication box in the Back Hall medication cart. She confirmed the investigation details as provided by the Administrator. The DON confirmed that RN #1 was driven via facility van to her home and returned with one damaged package of (30) Tramadol 50 mg, but not the second package of seven (7) Tramadol 50 mg. Observation revealed one bubble packed card of round white tablets labeled with the name of Resident #1 with the foil backing behind tablets numbered 1,3,5,8,12,22,23,24,25 and 28 punctured/torn. The DON reported that the facility did not have a copy of the pharmacy manifest for 4/17/26 because, based on security camera footage, RN #1 had thrown it away.On 6/03/26 at 2 PM, during an interview with Resident #1 revealed that she had pain in her legs that she described as occasional and pretty bad to sometimes severe. She explained that prior to admission by the facility she had fall while living at home and suffered a fracture which required surgical intervention and was at the facility for therapy with plans to return home following completion of therapy. She said that pain interfered with her ability to participate with therapy and her goal was to recover from surgery, gain strength through therapy and return home. She reported that requested PRN pain medication that was administered by facility nurses in a timely manner. Record review of the Order Summary Report for Resident #1 revealed a physician order dated 4/18/26 Ultram Oral Tablet 50 MG (milligrams) (Tramadol HCL) Give 50 mg by mouth every 6 hours as needed for Pain. Record review of the Face (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Sheet for Resident #1 revealed the facility admitted the resident on 4/14/26 with diagnoses that included displaced fracture of greater trochanter of left femur, subsequent encounter for closed fracture with routine healing, polyneuropathy and rheumatoid arthritis.Record review of the admission Minimum Data Set (MDS) with Assessment Reference Date of 4/20/26 for Resident #1 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Further MDS review revealed the facility assessed Resident #1's primary medical condition was fracture and other multiple traumas and that she reported frequent pain that occasionally limited day-to-day activities that she rated 5 on a 0-10 pain scale following surgical repair of fracture.