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Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255300 | A. Building<br>B. Wing | 11/07/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Willow Creek Retirement Center | 49 Willow Creek Lane<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>41680<br><br>Based on observation, interviews, record reviews, and facility policy review, the facility failed to ensure the comprehensive care plan interventions were implemented during Percutaneous Endoscopic Gastrostomy (PEG) tube care for one (1) of 19 care plans reviewed. Resident #30<br><br>Findings Include:<br><br>A review of the facility's policy titled Care Plans, dated 02/20/20 revealed, Each resident will have a person-centered plan of care to identify problems, needs, and strengths that will identify how the interdisciplinary team will provides care . PROCEDURE: . 6. Staff approaches are to developed for each problem/strength/need. Assigned disciplines will be identified to carry out the intervention .<br><br>A record review of Resident #30's Comprehensive Care Plan with a start date of 4/4/2019 revealed Adequate fluid/nutritional intake .Intervention .Keep head of bed elevated at all times .Cleaning peg site with normal saline. Pat the site dry with gauze .for skin protection.<br><br>On 11/06/24 at 1:25 PM, during an observation of PEG site care, Licensed Practical Nurse (LPN) #1 lowered the head of the bed to a flat position while the pump continued to infuse the feeding. After cleaning the PEG site, LPN #1 did not dry the PEG tube site prior to applying the split gauze dressing.<br><br>During an interview with LPN #1 on 11/06/24 at 1:35 PM, she acknowledged that she did not follow the care plan for Resident #30 when she lowered the bed of Resident #30 while the feeding continued to infuse and did not dry the PEG site before applying the split gauze dressing.<br><br>On 11/07/24 at 12:48 PM, during an interview with the Director of Nursing (DON), she stated that she expects staff to follow the care plan when providing care.<br><br>On 11/07/24 at 3:00 PM, during an interview with LPN #2, the Minimum Data Set (MDS)/Care Plan Nurse, she explained that staff are expected to adhere to the plan of care, as the purpose of the care plan is to guide the staff in providing appropriate care.<br><br>(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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A record review of the Admission Record revealed the facility admitted Resident #30 on 03/22/19. The resident had diagnoses that included Dysphagia, Oropharyngeal Phase and Encounter for Attention to Gastrostomy.<br><br>A record review of Resident #30's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/16/24 revealed a Brief Interview for Mental Status (BIMS) score of ninety-nine (99), indicating severely impaired cognition. Section K was coded for PEG tube usage. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>41680<br><br>Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure the physician orders were followed related to the care of a resident with a Percutaneous Endoscopic Gastrostomy (PEG) tube for one (1) of (19) sampled residents. Resident #30.<br><br>Findings Include:<br><br>A review of the facility's policy titled, Dressing Change, policy (undated) revealed, A dressing change will be done to promote wound healing, prevent infection and to provide an opportunity for wound assessment.<br><br>On 11/06/24 at 1:25 PM, during an observation of PEG tube site care, Licensed Practical Nurse (LPN) #1 lowered the head of the bed to a flat position while Resident #30's feeding pump was infusing Glucerna 1.2 at 50 cubic centimeters (cc) per hour. LPN #1 then proceeded to clean the PEG site with gauze in a circular motion without drying the site afterward.<br><br>On 11/06/24 at 1:35 PM, during an interview with LPN #1 , she admitted she forgot to place the feeding pump on hold before positioning the bed flat to conduct care. She acknowledged that she should have dried the site before applying a split gauze.<br><br>During an interview on 11/07/24 at 12:48 PM, the Director of Nursing (DON), stated that LPN #1 should have stopped the pump. She explained that Resident #30 could aspirate if the pump continues infusing while the bed is flat. She also noted that failing to dry the site could increase the risk of infection.<br><br>A record review of the Admission Record revealed the facility admitted Resident #30 on 03/22/19. The resident had diagnoses that included Dysphagia, Oropharyngeal Phase and Encounter for Attention to Gastrostomy.<br><br>A record review of the Order Summary Report, revealed Resident #30 had active orders as of 11/07/24 that included an order dated 1/13/24 to keep the head of the bed elevated 30-90 degrees while tube feeding was infusing and an order dated 1/31/24 to clean the PEG site with normal saline, and pat dry with gauze before applying a split gauze to the PEG site daily for skin protection.<br><br>A record review of Resident #30's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/16/24 revealed a Brief Interview for Mental Status (BIMS) score of (99), indicating severely impaired cognition. Section K was coded for PEG tube use. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>50751<br><br>Based on observation, interviews, record review, and facility policy review, the facility failed to prevent significant medication errors for one (1) of six (6) residents observed for medication administration. Resident #9<br><br>Findings Include:<br><br>A review of the facility's policy titled Medication Administration Guidelines, (undated), revealed, Medications are administered as prescribed .18. Prior to administration, the medication and dosage schedule on the resident's MAR/TAR or EMAR/ETAR is compared with the medication label. Information on the medication should be checked against the MAR/ETAR at least three times during the med preparation and administration process .<br><br>During an observation on 11/04/24 at 8:35 AM, Licensed Practical Nurse (LPN) #3 pulled medications for Resident #9. While pulling medications for an order of Lorazepam Oral Tablet 0.5 mg (milligram) that was to be given once daily for Anxiety Disorder, LPN #3 instead pulled a tablet for Alprazolam 1 mg, 1.5 tablets (to equal 1.5 mg) to be given at bedtime. This medication was placed into the medication cup with the resident's other medications to be administered. LPN #3 confirmed she intended to administer the medication to Resident # 9. The State Agency (SA) questioned whether the Alprazolam medication was due at that time and LPN #3 confirmed that the medication was not due and verified it as the incorrect medication for that time. LPN #3 called LPN #5, and together, they wasted the medication.<br><br>During an interview on 11/07/24, the Director of Nursing (DON) stated that her expectation was for staff to ensure residents receive the correct medications as prescribed. She emphasized that administering incorrect medications, especially narcotics, could result in adverse outcomes, including lethargy or oversedation, and expressed concern regarding the observed error.<br><br>A record review of the Admission Record revealed the facility admitted Resident #9 on 01/21/15. The resident had diagnoses that included Anxiety Disorder, Depression, and Insomnia.<br><br>A record review of the Order Summary Report, with active orders as of 11/07/24 revealed Resident #9 and order for the Lorazepam Oral Tablet 0.5 mg (to be given once daily for Anxiety Disorder, unspecified), with an order start date of 10/02/24 and Alprazolam 1 mg, with an order for 1.5 tablets (to equal 1.5 mg) to be given at bedtime, with an order start date of 10/01/24. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>41680<br><br>Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure proper infection control practices were implemented during Percutaneous Endoscopic Gastrostomy (PEG) tube site care and wound care for two (2) of (19) sampled residents. Residents<br><br>#14 and #30<br><br>Findings Include:<br><br>A review of the facility's policy titled Hand Hygiene, dated 06/12/22 revealed, All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors . If your task requires gloves, perform hand hygiene prior to donning gloves, and sanitize or wash hands after removing gloves .<br><br>Resident #14<br><br>On 11/06/24 at 1:08 PM, during an observation of wound care, Licensed Practical Nurse (LPN) #1/Wound Care Nurse, performed a dressing change on Resident #14's right elbow. After removing the soiled dressing from the resident's arm, she placed it on the resident's bedside table without using a barrier and did not use a red biohazard bag for disposal. LPN #1 then proceeded to apply a new dressing without removing her soiled gloves.<br><br>On 11/06/24 at 1:10 PM, LPN #1 admitted that she did not use a barrier or a red biohazard bag for the soiled dressing, acknowledging failure to do so could lead to infection.<br><br>During an interview with the Infection Preventionist on 11/07/24 at 9:55 AM, she stated that all staff are expected to follow infection control guidelines, including using appropriate containers for disposing of soiled dressings to prevent the spread of infection.<br><br>During an interview on 11/07/24 at 10:00 AM, the Director of Nursing (DON) emphasized her expectation that staff adhere to infection prevention protocols when performing wound care. She stated that failure to change gloves or using clean surfaces for soiled dressing could increase the risk of the spread of infection.<br><br>A record review of Resident #14's Admission Record revealed the facility admitted the resident on 07/16/24. The resident had diagnoses that included Dementia, and Pressure Ulcer of Right elbow, Stage 3.<br><br>Resident #30<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 11/06/24 at 1:25 PM, during an observation of LPN #1 providing PEG tube site care for Resident #30 revealed LPN #1 entered the room without washing her hands or using hand sanitizer. She held one pair of clear gloves upon entry and did not perform hand hygiene before donning the gloves. After lowering the head of the bed with her bare hands, she applied gloves, removed the soiled split gauze from the PEG site, placed it in a red bag, and cleaned the site with gauze and normal saline and applied a new split gauze to the site. During the procedure, she did not wash her hands, use hand sanitizer, or change gloves.<br><br>During an interview with LPN #1 at 1:35 PM on 11/06/24, she admitted that she failed to wash her hands or use hand sanitizer upon entering the room and acknowledged she should have performed hand hygiene and changed gloves at different stages of the care. She recognized that her actions could lead to cross-contamination and infection.<br><br>At 12:48 PM on 11/06/24, the DON confirmed that LPN #1 should have performed hand hygiene before and during the procedure. The DON noted that failure to follow these infection control protocols could lead to the spread of infection.<br><br>A record review of the Admission Record revealed the facility admitted Resident #30 on 03/22/19. The resident had diagnoses that included Dysphagia, Oropharyngeal Phase and Encounter for Attention to Gastrostomy.<br><br>48669<br><br>50751 |