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	03/05/2026

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and facility policy review, the facility failed to follow infection prevention and control practices during resident care by failing to perform hand hygiene during incontinent care (Resident #66), failing to implement Enhanced Barrier Precautions during catheter care (Resident #13), and contaminating environmental surfaces with soiled gloves during wound care (Resident #36) for three (3) of four (4) care observations.Findings include: A review of the facility's policy, Infection Prevention and Control Program, revised 3/23/23, revealed, .It is the policy of this facility to.maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. A review of the facility's policy, Hand Hygiene, revised 6/12/22, revealed, .Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection.Policy Explanation and Compliance Guidelines.1. Staff will perform hand hygiene when indicated.6. Additional considerations: The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.Hand Hygiene Table.When, during resident care, moving from a contaminated body site to a clean body site.Either Soap and Water or Alcohol Based Hand Rub. A review of the facility's policy, Enhanced Barrier Precautions, revised 9/29/25, revealed, .It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.Enhanced Barrier Precautions refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities.10. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or. discontinuation of the indwelling medical device. Resident #66 A record review of the Face Sheet revealed the facility admitted Resident #66 on 3/10/21 with diagnoses including chronic kidney disease. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/16/25 revealed Resident #66 had a Brief Interview for Mental Status (BIMS) score of (15), which indicated the resident was cognitively intact. On 3/3/26 at 9:56 AM, during an observation, Certified Nursing Aide (CNA) #3 provided incontinent care to Resident #66. CNA #3 explained the procedure to the resident and provided privacy. CNA #3 donned gloves and began peri-care without performing hand hygiene prior to initiating care. During the (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	care, CNA #3 removed gloves and applied new gloves multiple times but did not perform hand hygiene between glove changes. CNA#3 continued peri-care, including cleaning fecal material, while changing gloves several times without performing hand hygiene. On 3/3/26 at 10:29 AM, during an interview, CNA #3 confirmed she did not perform hand hygiene between glove changes during Resident #66's care. CNA #3 stated she washed her hands after completing care but acknowledged she should have performed hand hygiene when removing gloves and before donning clean gloves. On 3/3/26 at 3:21 PM, during an interview, the Director of Nursing (DON) stated staff should perform hand hygiene upon entering the resident room and each time gloves are removed during care. The DON stated hand hygiene is required to prevent the spread of infection between residents and environmental surfaces. Resident #13 A record review of the Face Sheet revealed the facility admitted Resident #13 on 2/10/21 with diagnoses including Retention of Urine. A record review of the Order Summary Report revealed Resident #13 had a physician order dated 1/15/25 for urinary catheter care which instructed staff to provide catheter care with soap and water every shift and as needed. A record review of the Quarterly MDS with an ARD of 2/2/26 revealed Resident #13 had a BIMS score of six (6), which indicated the resident's cognition was severely impaired. On 3/3/26 at 2:14 PM, during an observation, CNA #1 assisted by CNA #2 provided Foley (indwelling catheter) care to Resident #13. CNA #1 gathered supplies, entered the room, explained the procedure, performed hand hygiene, and applied clean gloves. During the catheter care observation, the staff did not don a gown while providing care to a resident with an indwelling urinary catheter. On 3/4/26 at 2:34 PM, during an interview, CNA #2 confirmed she did not put on a gown prior to providing catheter care. CNA #2 stated the purple dot next to the resident's name served as a reminder that staff should wear a gown when providing care and acknowledged she forgot to don the gown. On 3/4/26 at 2:40 PM, during an interview, CNA #1 confirmed staff did not wear a gown while providing catheter care to Resident #13. CNA #1 stated gowns should be worn during care to reduce the risk of spreading infection between residents. On 3/4/26 at 4:15 PM, during an interview, the DON stated staff should wear gowns when providing direct care to residents who require Enhanced Barrier Precautions. The DON stated the purpose of Enhanced Barrier Precautions is to reduce the spread of infection between residents and staff. Resident #36 A record review of the Face Sheet revealed the facility admitted Resident #36 on 11/10/17 with diagnoses including Dementia. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/3/26 revealed Resident #36 required a staff assessment for mental status and had long-term memory impairment. A record review of the Order Summary Report revealed Resident #36 had a physician order dated 2/11/26 for wound care to a pressure ulcer on the left great toe. On 3/4/26 at 12:16 PM, during an observation, Licensed Practical Nurse (LPN) #4 performed wound care to Resident #36's pressure ulcer on the left great toe. During the procedure, while wearing the same gloves used during wound care, LPN #4 picked up a dressing from the floor to discard and then used the same gloves to touch the bed remote control to lower the bed. On 3/4/26 at 12:21 PM, during an interview, LPN #4 confirmed she touched the wound site, the floor, and the bed remote control while wearing the same gloves. LPN #4 acknowledged she should have removed her gloves and performed hand hygiene before touching environmental surfaces in the room. On 3/5/26 at 9:59 AM, during an interview, the DON stated staff should remove contaminated gloves and perform hand hygiene before touching other surfaces during resident care. The DON stated failure to follow infection control practices could result in contamination of environmental surfaces and the spread of infection.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident's right to reasonable accommodation of communication needs when a functioning bedside telephone was not provided for one (1) of (18) sampled residents. Resident #9.Findings include:A review of the facility's policy, Resident Rights, revised 10/24/22, revealed, .Resident rights.The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.A record review of the Face Sheet revealed the facility admitted Resident #9 on 6/3/25 with diagnoses including Alzheimer's Disease.A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/17/25, revealed Resident # 9 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated his cognition was severely impaired.On 3/2/26 at 12:37 PM, during an observation and interview, Resident #9 had a telephone sitting at the bedside which was not functioning. Resident #9's wife stated she had been attempting for approximately three months to have an incoming-call-only telephone set up at the resident's bedside because the resident had forgotten how to use his cell phone due to dementia. She stated she had spoken with the Social Worker regarding assistance with setting up the phone. She explained the Social Worker instructed her to purchase the phone and contact the phone company. The wife stated she had purchased the phone and brought it to the facility; however, she was told to contact the phone company to activate the line. She reported the phone company did not understand what was needed and stated the facility had not followed up to assist with ensuring the phone was working even though the phone remained at the resident's bedside.On 3/3/26 at 2:00 PM, during an observation and follow-up interview, the bedside telephone for Resident #9 remained in the room but was not operational. Resident #9's wife stated the bedside telephone was still not functioning. She confirmed she had previously spoken with the Social Worker about getting the phone set up but stated the issue had not been resolved and the phone remained in the resident's room without being operational.On 3/4/26 at 9:15 AM, during an observation, Resident #9 continued to have a telephone at the bedside which was not functioning.On 3/4/26 at 9:35 AM, during an interview, the Social Worker stated the typical process for setting up a landline telephone was for the resident's family to contact the phone company to establish service in the resident's room. The Social Worker stated Resident #9's wife had approached her approximately one month earlier about setting up a phone and she instructed the wife to contact the phone company. The Social Worker stated she believed the phone had been set up but acknowledged she did not follow up with the family to confirm the phone was working or to request a demonstration.On 3/4/26 at 9:49 AM, during an interview, the Maintenance Director stated the resident's family had not notified him that a phone had been brought to the facility to be installed at the resident's bedside. He stated the facility does not typically provide phones for residents and indicated he was unaware the phone needed to be set up.On 3/4/26 at 9:50 AM, during an interview, the Administrator stated it was not the facility's responsibility to follow up with the resident's family regarding the setup of the bedside phone. The Administrator stated families typically contact the phone company directly to arrange for telephone service in the resident's room.On 3/5/26 at 9:06 AM, during an interview, the Director of Nursing (DON) stated the facility should have followed up with the resident's family regarding the request for a bedside phone. The DON stated residents have the right to communicate with individuals of their choosing and acknowledged the facility failed to ensure the phone was operational for Resident #9.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident's right to a clean, comfortable, and homelike environment when the air conditioning vent in the resident's room contained excessive dust and debris for one (1) of (18) sampled residents. Resident #9.Findings include:A review of the facility's policy, Resident Rights, revised 10/24/22, revealed, .Resident rights.8. Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment.A record review of the Face Sheet revealed the facility admitted Resident #9 on 6/3/25 with diagnoses including Alzheimer's Disease.A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/17/25, revealed Resident # 9 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated his cognition was severely impaired.On 3/2/26 at 12:37 PM, during an observation, the air conditioning vent in Resident #9's room contained visible dust and debris.On 3/3/26 at 1:58 PM, during an observation and interview, the air conditioning vent in Resident #9's room continued to be visibly dirty with dust and debris. Resident #9's wife stated she had notified Licensed Practical Nurse (LPN) #1 approximately one month earlier that the air conditioning vent was dusty when the resident moved into the room. She stated she was told maintenance had been notified and the vent would be cleaned, but it had not been addressed.On 3/3/26 at 4:03 PM, during an interview, LPN #1 stated she had spoken with maintenance staff approximately one month earlier about the condition of Resident #9's air conditioning vent and explained it contained dust, dried debris, and what appeared to be food particles. LPN #1 stated she did not submit a maintenance request ticket because she had spoken with maintenance staff directly.On 3/3/26 at 4:20 PM, during an interview, the Maintenance Director stated he had not received a maintenance request regarding the air conditioning vent in Resident #9's room. The Maintenance Director stated maintenance requests should be entered into the maintenance request log so the issue can be tracked and completed. The Maintenance Director reviewed the maintenance request log for D Hall and confirmed no request had been logged regarding cleaning the air conditioning vent in Resident #9's room.On 3/5/26 at 9:06 AM, during an interview, the Director of Nursing (DON) stated nursing staff should document maintenance issues using a maintenance request form or report the issue through the facility's maintenance request process to ensure repairs are completed in a timely manner.

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. Based on observation, interview, record review, and facility policy review, the facility failed to implement a resident's comprehensive care plan intervention related to Enhanced Barrier Precautions for one (1) of (18) care plans reviewed. Resident #13.Findings include:A review of the facility's policy, Care Plans, updated 2/20/20, 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 provide care.Procedure.Staff approaches are to be developed for each problem/strength/need. Assigned disciplines will be identified to carry out the intervention.A record review of the Care Plan Report revealed Resident #13 had a Focus of The resident has indwelling foley catheter. with Interventions that included Enhanced Barrier Precautions.On 3/3/26 at 2:14 PM, during an observation, Certified Nursing Aide (CNA) #1 assisted by CNA #2 provided Foley catheter care to Resident #13. Staff did not wear a gown while providing catheter care despite the care plan intervention requiring Enhanced Barrier Precautions.On 3/4/26 at 2:34 PM, during an interview, CNA #2 confirmed she did not wear a gown during Resident #13's catheter care and stated she forgot to put it on. CNA #2 stated the purple dot by the resident's name served as a reminder that staff should wear a gown when providing care.On 3/4/26 at 2:40 PM, during an interview, CNA #1 confirmed staff did not wear a gown while providing care to Resident #13. CNA #1 stated she was responsible for ensuring Enhanced Barrier Precaution supplies were stocked outside the resident's room and acknowledged the care plan intervention requiring a gown was not followed.On 3/4/26 at 4:15 PM, during an interview, the Director of Nursing (DON) stated staff should wear gowns when providing direct care to residents who require Enhanced Barrier Precautions and confirmed staff are expected to follow care plan interventions.On 3/4/26 at 4:33 PM, during an interview, Registered Nurse (RN) #1, the care plan nurse, stated the care plan is intended to guide staff in providing resident care and should be followed when delivering care. RN #1 explained staff are expected to follow the care plan interventions.A record review of the Face Sheet revealed the facility admitted Resident #13 on 2/10/21 with diagnoses including Retention of Urine.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/2/26 revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of six (6), which indicated the resident's cognition was severely impaired.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, record review, and facility policy review, the facility failed to ensure a Foley (indwelling catheter) was properly secured with a leg strap to prevent catheter movement and trauma for one (1) of two (2) residents reviewed for urinary catheters. Resident #13.Findings include:A review of the facility's policy, UTI (Urinary Tract Infection) Prevention with Indwelling Catheter Use, undated, revealed, .A resident with an indwelling catheter is susceptible to urinary tract infections.Policy Explanation.7. Catheter tubing should be secured to the resident's leg or bed clothing to prevent pulling and irritation of the urinary meatus.On 3/3/26 at 2:14 PM, during an observation, Certified Nursing Aide (CNA) #1 assisted by CNA #2 provided Foley catheter care to Resident #13 and the catheter tubing was not secured with a leg strap. On 3/4/26 at 2:34 PM, during an interview, CNA #2 confirmed Resident #13 did not have a leg strap in place and stated she forgot to obtain one. CNA #2 stated the purpose of the leg strap was to keep the Foley catheter from being pulled out and believed it was the nurse's responsibility to ensure the leg strap was in place.On 3/4/26 at 4:15 PM, during an interview, the Director of Nursing (DON) stated the leg strap was used to keep the Foley catheter secured and maintain proper flow. The DON stated all nursing staff were responsible for ensuring a leg strap was in place and that any staff member could obtain a leg strap and secure the catheter. The DON stated the purpose of the leg strap was to prevent trauma.A record review of the Face Sheet revealed the facility admitted Resident #13 on 2/10/21 with diagnoses including Retention of Urine.A record review of the Order Summary Report revealed Resident #13 had a Physician's Order, dated 1/15/25, for Urinary Catheter Care: nurse is to ensure that catheter care is provided with soap and water every shift and as needed. Leg strap secured.every shift.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/2/26 revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of six (6), which indicated the resident's cognition was severely impaired.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, record review, and facility policy review, the facility failed to ensure medications were stored securely when medications were left unattended at a resident's bedside for one (1) of two (2) medication storage observations. Resident #33.Findings include:A review of the facility's policy, Medication Storage, undated, revealed, .Medication supply must be accessible only to licensed nursing personnel, or staff members lawfully authorized to administer medications. All drugs, treatments and biologicals must be stored securely.On 3/3/26 at 9:00 AM, during an observation and interview, Resident #33 pointed to a medication cup sitting on the bedside table. The medication cup contained six (6) pills described as three round pills, two pink pills, and one white oblong pill. Resident #33 stated she did not know why she had to take so many medications.On 3/3/26 at 9:10 AM, during an observation, Licensed Practical Nurse (LPN) #3 entered the room and spoke with Resident #33 regarding the medications. LPN #3 stated to the resident that when she previously left the room the resident had the pills in her hands. Resident #33 stated she had told the nurse she wanted to eat first. LPN #3 then handed the medication cup to the resident, and the resident took the medications.On 3/3/26 at 9:12 AM, during an interview, LPN #3 stated she should not have left the medications in the resident's room and should have remained with the resident to ensure the medications were taken. LPN #3 stated leaving medications unattended could result in the resident discarding the medications or another resident entering the room and taking them.On 3/3/26 at 3:21 PM, during an interview, the Director of Nursing (DON) stated nurses should not leave medications at the bedside. The DON stated physician orders require medications to be administered as ordered and leaving medications unattended could allow another resident access to them.A record review of the Face Sheet revealed the facility admitted Resident #33 on 9/12/24 with diagnoses including Essential (Primary) Hypertension and Hyperlipidemia.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/16/25 revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was cognitively intact.A record review of the Order Summary Report revealed Resident #33 had active physician orders for Ativan Oral Tablet 0.5 mg (milligrams) by mouth one time a day dated 6/2/25, Losartan Potassium Tablet 100 mg by mouth daily dated 9/12/24, Aspirin Chewable 81 mg by mouth daily dated 9/12/24, Mobic Oral Tablet 15 mg by mouth daily dated 4/2/25, Cholecalciferol Oral Tablet 2000 units by mouth daily dated 9/29/25, and Cyanocobalamin Oral Tablet 1000 units by mouth daily dated 9/29/25.A record review of the Medication Administration Record (MAR) revealed Licensed Practical Nurse (LPN) #3 documented Ativan, Losartan, Aspirin, Mobic, Cholecalciferol, and Cyanocobalamin as administered during the 8:00 AM medication pass on 3/3/26.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review, staff interview, and facility policy review, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to sustain corrective actions to prevent recurrence of a previously cited deficiency, specifically, the facility was cited for failing to ensure proper infection control practices related to hand hygiene during Percutaneous Endoscopic Gastrostomy (PEG) tube site care during an annual recertification survey on 11/7/24 and was cited again for the same deficiency during the current survey, demonstrating that QAPI failed to sustain ongoing monitoring and oversight to prevent recurrence for one (1) of seven (7) deficiencies cited. F880Findings include:A review of the facility's policy, Quality Assurance Performance Improvement, revised 5/7/18, revealed .Policy: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life.Record review of the Provider History Profile revealed the facility received a citation for F880 - Infection Prevention and Control that had a Plan/Date of Correction of 12/4/2024. Record review of the Centers for Medicare and Medicaid Services (CMS)-2567 (a record that identifies the federal regulation in violation and describes the findings of noncompliance and the facility's plan of correction), with a survey date of 11/7/24 revealed, .Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure proper infection controls practices were implement.for two (2) of (19) sampled residents.During the current recertification survey, the facility failed to follow infection prevention and control practices during resident care by failing to perform hand hygiene during incontinent care (Resident #66), failing to implement Enhanced Barrier Precautions during catheter care (Resident #13), and contaminating environmental surfaces with soiled gloves during wound care (Resident #36) for three (3) of four (4) care observations.In an interview on 3/6/26, at 1:17 PM, the Director of Nursing (DON) explained that, based on current information from the State Agency (SA), the lack of hand hygiene during patient care has been a recurring issue since the last survey. The facility has not monitored this issue or implemented any performance improvement plans since the previous plan of correction, such as tracking and measuring outcomes. The DON emphasized that it is important for staff to maintain hand hygiene during care to prevent the spread of infections.At 1:30 PM on 3/6/26, in an interview with the Administrator, he revealed that he has been working at the facility since January 2026. During this time, he has been conducting Quality Assurance Performance Improvement (QAPI) meetings monthly. In those meetings, he does not recall identifying or addressing the continued tracking or monitoring of hand hygiene during resident care since the last plan of correction was implemented for the facility. However, he confirmed that this monitoring should occur, as required by their current policy.