

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265607	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Willowcreek Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 250 New Florissant Road South Florissant, MO 63031	

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)
<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>22409</p> <p>Based on interview and record review, the facility failed to ensure concerns voiced during Resident Council meetings were consistently addressed in writing and returned to the Resident Council for review in a prompt and timely manner. Resident #2, the Resident Council President, confirmed the facility did not always respond to the Resident Council's concerns. This deficient practice had the potential to affect all residents who resided at the facility. The census was 120.</p> <p>Review of the facility's Resident Council policy, revised on 6/2020, showed:</p> <ul style="list-style-type: none"> -Purpose: To promote the exercise of a resident's right to organize and participate in resident groups at the Facility; -Policy: The facility encourages residents' involvement and input in the operation of the Facility through the Resident Council; -Responsibilities of the Resident Council: <ul style="list-style-type: none"> -Making recommendations for the improvement of resident services provided by the Facility; -Reviewing reports submitted to the Council and making recommendations and/or taking appropriate action; -Studying problem areas and making recommendations for their solution; -Maintaining minutes of all meetings and submitting a copy to the Administrator for review; -A Resident Council response form is utilized to track issues and their resolution; -If the Council raises an issue of concern, the Department responsible for the issue or service is responsible for addressing the item(s) of concern promptly; -The facility will respond in writing to written request or concerns of the Resident Council in a prompt and timely manner; -The Facility will respond to issues discussed by the Resident Council and may use Resident Council Department Response Form; <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 265607	If continuation sheet Page 1 of 41

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The Facility's Quality Assessment & Assurance Committee reviews the Resident Council minutes from the Resident Council as part of its quality review.</p> <p>Review of the facility's Resident Council Follow-Up form, showed: All complaints/concerns identified during Resident Council will be documented as a grievance on the grievance form. This will include a detailed description of the complaint. It will then be delegated to the appropriate department for resolution. This resolution will be documented on the grievance form as well. A designee will then meet with the resident to discuss the resolution and ensure all parties are satisfied. The completed grievance will then be forwarded to the Administrator for review and approval. These concerns will then be reviewed at the next Resident Council as Old Business to ensure that concerns have not persisted.</p> <p>Review of the facility's Resident Council meeting minutes, dated 8/15/24 at 2:00 P.M., showed:</p> <p>-Staff members present: the former Director of Nursing (DON), Activity Director (AD) and Activity Aide (AA) F;</p> <p>-18 residents attended, including: Resident #3, Resident #2, and Resident #14;</p> <p>-New Business (list topics discussed and recommendations): discussed Resident #3 is a bully. Always arguing with staff and peers;</p> <p>-No facility response to the Resident Council regarding residents' concerns about Resident #3's behaviors.</p> <p>Review of the facility Resident Council meeting minutes, dated 12/19/24 at 1:30 P.M., showed:</p> <p>-Staff members present: AD and AA F;</p> <p>-26 residents attended, including: Resident #2, Resident #4, Resident #7, and Resident #14;</p> <p>-Other Concerns: Residents are complaining about Resident #3 bullying, cursing all the time, taking their cigarettes and nothing is being done;</p> <p>-No facility response to the Resident Council's concerns.</p> <p>During an interview on 1/24/25 at 10:00 A.M., Resident #2 said Resident #3 gave other residents a hard time by threatening them, calling them names and calling them outside to fight. Resident #3 told them he/she had been in prison to intimidate them. He/She made other residents nervous to be around him/her. All the residents were afraid of Resident #3. Numerous residents had complained about him/her. This had been going on for months. He/She did not know if anything would be done about Resident#3's behaviors, because nothing seemed to have been done so far. The facility did not always send a response to the Resident Council's concerns.</p> <p>During an interview on 1/28/25 at 10:57 A.M., the AD said any concerns raised by the residents during Resident Council meetings were given to the department managers. The department managers were supposed to respond on how they were going to correct the concerns within five days. She did not receive a response back for the 8/15/24, and 12/19/24, Resident Council meetings.</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/29/25 at 12:30 P.M., the Administrator said the Resident Council policy was current and what she expected staff to follow. If residents voiced concerns during Resident Council, the AD was supposed to provide those concerns to whichever department was responsible and the department manager should respond in writing to the Resident Council within five days. The department manager had five days to respond in writing to the Resident Council. She was not aware there was no response and did not know why there were no response to the Resident Council's concerns on 8/15/24, and 12/19/24 regarding Resident #3's behaviors.</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409</p> <p>Based on observation, interview, and record review, the facility failed ensure residents were free from abuse by Resident #3, who yelled, cursed and threatened them. Resident #3 was described as bullying residents and used racial slurs towards his/her roommate. Residents refused to go to activities or eat in the dining room to avoid being around the resident. The census was 120.</p> <p>The Administrator was notified on 3/3/25 at 11:15 A.M., of an immediate jeopardy (IJ) which began on 1/29/25. The IJ was removed on 1/30/25 as confirmed by surveyor on-site verification.</p> <p>Review of the facility Abuse Prevention and Prohibition Program policy, revised on 10/24/2022, showed:</p> <p>-Purpose: To ensure the Facility establishes, operationalizes, and maintains and Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements;</p> <p>-Policy: Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property;</p> <p>-The facility is committed to protecting residents from abuse by anyone, including but not limited to Facility Staff, and other residents;</p> <p>-The Administrator is responsible for coordinating and implementing the Facility's abuse prevention policies, procedures, training programs, and systems;</p> <p>-Procedure:</p> <p>-Training: Covered individuals will be trained through orientation and on-going training sessions, no less than annually, on the following topics: Who is a covered individual responsible for reporting. Abuse prevention. Identification and recognition of signs and symptoms of abuse/neglect. Protection of residents during an abuse investigation. Appropriate interventions to deal with aggressive and/or catastrophic reactions of residents;</p> <p>-Prevention:</p> <p>-Staff, residents and families will be able to report concerns, incidents and grievances without of retribution or retaliation;</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Supervisors shall immediately intervene, correct, and report identified situations where abuse, neglect is at risk for occurring;</p> <p>-Residents identified by staff as exhibiting abusive behavior that requires professional services not provided in the Facility will be reviewed by the IDT (interdisciplinary team) and/or physician. Appropriate referrals will be made, and treatment plans will be modified;</p> <p>-The Facility maintains adequate staffing on all shifts to ensure that the needs of each resident are met;</p> <p>-The Facility conducts an ongoing review and analysis of abuse incidents and implements corrective actions to prevent future occurrences of abuse;</p> <p>-Resident Assessments and Care Planning are performed to monitor resident needs and address behaviors that may lead to conflict;</p> <p>-Identification:</p> <p>-The facility provides covered individuals with training to enable the identification of the following signs and symptoms of potential resident abuse and neglect;</p> <p>-Possible Signs and Symptoms of Psychological Abuse or Neglect, includes depression, withdrawal, and anger;</p> <p>-Investigation:</p> <p>-The Facility promptly and thoroughly investigates reports of resident abuse, mistreatment, neglect, injuries of unknown source, or criminal acts;</p> <p>-The Facility has protocols for investigations;</p> <p>-If the Administrator receives a report of an incident or suspected incident of resident abuse, mistreatment, neglect, the Administrator or designee, may appoint a member of the Facility's management team to investigate the alleged incident;</p> <p>-Protection: The Facility protects residents from any harm that could result from abuse investigations.</p> <p>Review of the facility's Violence Between Residents policy, dated 8/2020, showed:</p> <p>-Purpose: To protect the health and safety of residents by ensuring that altercations between residents are promptly reported, investigated, and addressed by the facility;</p> <p>-Policy: The Facility acts promptly and conscientiously to prevent and address altercations between residents;</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Prevention: Facility Staff monitors residents for aggressive or inappropriate behavior toward other residents, family members, visitors, or Facility Staff. Any occurrences of such behavior are promptly reported to the Charge Nurse, the Director of Nursing (DON), and the Administrator;</p> <p>-Response to an Altercation: Separate the residents, and institute measures to calm the situation. Determine what happened, including what might have led to aggressive conduct on the part of one or more residents involved in the altercation. Notify each resident's representative and Attending Physician of the incident. Review the events with the Charge Nurse and DON, including interventions staff can take to prevent additional incidents. Consult with Attending Physician to identify treatable conditions such as acute psychosis that may have caused or contributed to the problem. Make any necessary changes in the Care Plan for any or all of the involved residents as necessary. Document in the resident's interventions and their effectiveness in the resident's medical record. Consult with psychiatric services as needed for assistance in assessing the resident, identifying causes, and developing a Care Plan for intervention and management as necessary or as may be recommended by the Attending Physician or Interdisciplinary Team. Complete the Incident report and document the incident, findings, and any corrective measures taken in the resident's medical/clinical record. If, after carefully evaluating the situation, it is determined that care cannot be readily given within the Facility, transfer the resident. Report incidents, findings, and corrective measures to appropriate agencies.</p> <p>Review of Resident #3's admission face sheet showed:</p> <p>-Admission 6/6/24;</p> <p>-The resident was listed as his/her own responsible party.</p> <p>Review of the resident's progress notes, located in the electronic health record (EHR), dated 6/6/24 at 12:52 P.M., showed the resident arrived at 12:00 noon, alert and oriented x 4 (person, place, time and situation). Got off ambulance stretcher and walked to room with a steady gait.</p> <p>Review of the Guidelines for Resident Behavior, signed by the resident and co-signed by the Social Service Director (SSD) on 6/6/24, showed:</p> <p>-General Conduct: residents are expected to treat staff, other residents with respect, dignity and privacy. Conduct must be consistent with accepted community standards, local, federal and state laws. Unacceptable conduct includes but is not limited to physical abuse, verbal abuse. This conduct is not permitted on or about the facility;</p> <p>-Non-Compliance: if we determine that residents' behavior is contrary to these rules and is compromising their health care or that of other residents, these residents will be subject to administrative actions.</p> <p>Review of the resident's care plan, located in the EHR, showed:</p> <p>-Problem, 6/6/24: Resident has a mood problem, depression;</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Goal: Resident will not experience any increase in signs and symptoms of mood disturbance. Interventions: Administer medications as ordered. Behavioral health consult as needed. Communicate with resident regarding mood state and treatment. Encourage resident to express feelings. Encourage resident to participate in activities of choice. Encourage to maintain as much independence and control/decision making as possible. Notify medical provider of increased episodes of mood disturbance;</p> <p>-Problem, 6/13/24: Resident has a behavior problem. Resident was noted to speak rudely to roommate, eating off other residents' plates, verbally aggressive with staff, disrespectful to staff;</p> <p>-Goal: resident will have fewer episodes of behaviors through review date. Interventions/Tasks (6/13/24);</p> <p>-Interventions: speak in calm manner. Behavioral health consults as needed. Communicate with resident regarding behaviors and treatment. Consult with Pastoral care, Psych services, and/or support groups. Minimize potential for behaviors by offering tasks that divert attention. Monitor behavioral episodes and attempt to determine underlying causes. Intervene as necessary to protect the rights and safety of others. Encourage not to curse or speak disrespectfully and/or aggressive to staff. Notify medical provider of increased episodes of behaviors.</p> <p>-6/14/24: Encouraged to speak to roommate respectfully and encouraged not to eat off of other resident's plates.</p> <p>Review of the resident's record showed there was no behavior management program or ongoing assessment, monitoring, and evaluation of the effectiveness of the behavior management program including the effectiveness of psychoactive drugs documented.</p> <p>Review of the resident's progress note, dated 6/12/24 at 2:26 P.M., showed the resident's physician saw the resident at the facility.</p> <p>Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/13/24, showed:</p> <p>-Speech Clarity: clear speech, distinct intelligible words;</p> <p>-Makes Self Understood: ability to express ideas and wants: understood;</p> <p>-Ability To Understand Others: understood;</p> <p>-Cognitively intact;</p> <p>-Behavioral Symptoms: Verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others): behavior not exhibited;</p> <p>-Mobility Devices: walker;</p> <p>-Walk 150 feet (ft): once standing the ability to walk at least 150 ft in a corridor or similar space: supervision or touching assistance, helper provides verbal cues or touching/steadying assistance as resident completes activity;</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Diagnoses of high blood pressure, diabetes mellitus (high blood sugar) and depression.</p> <p>Review of the resident's medication administration record (MAR, a form where nurse documents medication administration and behavioral episodes) dated 6/6/24 through 6/30/24, located in the EHR, showed:</p> <p>-6/6/24: Duloxetine HCl (antidepressant) 30 milligrams (mg) daily;</p> <p>-Behaviors: Verbally aggressive with staff: occurred 1 time on the evening shift (6/13/24);</p> <p>-Interventions: Encouraged not to speak disrespectfully and/or aggressive to staff on the evening shift (6/13/24);</p> <p>Review of the resident's progress notes, dated 6/13/24, showed no documentation the facility notified the resident's physician, psychiatrist, and/or the psychiatric NP about the resident's behavior on the evening shift of 6/13/24.</p> <p>Review of the resident's progress note, on 6/14/24 at 12:07 P.M., showed the SSD documented the resident said he/she was there short term and was just waiting on his/her apartment to be approved. Resident rights were reviewed including the facility guidelines for behavior, drugs, and smoking.</p> <p>Review of the resident's MAR, dated 7/1/24 through 7/31/24, showed no behaviors documented.</p> <p>Review of the resident's progress note, dated 7/3/24 at 6:59 P.M., showed:</p> <p>-Resident had verbal disagreement with another resident, nursing staff present at the time, no contact made. Resident separated from the other resident. Resident was calm sitting outside in the smoking area listening to music;</p> <p>-No SSD or IDT follow-up documented.</p> <p>Review of the resident's psychiatric note, completed by the psychiatric NP, dated 7/10/24, showed:</p> <p>-Diagnoses: post-traumatic stress disorder (a mental health disorder that can develop after witnessing a traumatic event), nicotine dependence, cocaine use (in remission), other specific personality disorders, and persistent mood disorder;</p> <p>-Medications: duloxetine HCl 30 MG daily;</p> <p>-Subjective: seen for regular follow-up, says he/she was still trying to make the best of his/her situation. Decides he/she does not want medication to help him/her stop flipping out. Discussed trying to stay calm and walking away from conflict, which I am not sure he/she was completely on board with. Denies symptoms of depression or anxiety. Just mood swings he/she says;</p> <p>-Objective: resident was engaged with examiner in a cooperative and polite manner. Mobility was within normal limits. Stream of mental activity was logical, relevant, coherent, and goal directed;</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Plan: will follow monthly. Discussed symptoms management. Discussed signs of depression, anxiety, changes in cognition and when to notify staff of symptoms.</p> <p>Review of the resident's progress notes showed:</p> <p>-7/11/24 at 6:22 A.M.: the resident had a verbal altercation with roommate. Resident was loud, disturbing, and using profane language. The resident slammed the door behind roommate;</p> <p>-7/11/24 at 10:29 A.M., IDT note (Administrator, former Director of Nursing (DON), SSD and Nursing Manager): verbal disagreement with roommate. The resident called roommate a racial slur. Roommate did not like this and told the resident so. The resident became upset when staff intervened. The resident left the room shutting the door loudly. The resident educated to be considerate of others' feelings and preferences. The resident verbalized understanding;</p> <p>-7/11/24 at 3:04 P.M., completed by the SSD: spoke with the resident about his/her disagreement with roommate this morning. He/She said he/she closed the door but did not mean to slam it. Explained to him/her if he/she has a problem with his/her roommate just come and speak to them. Also spoke about changing rooms. He/She said he/she was happy with that;</p> <p>-7/13/24 at 11:17 A.M., documented by the Administrator: met with resident for psychosocial follow-up. Said he/she likes his/her new room and new roommates. Reinforced with resident that he/she must remain respectful with facility staff. Said he/she understands and was working on it. He/She feels that due to his/her size, he/she may come across as more upset than he/she actually was. Reeducated that he/she can bring any concerns to facility management, social service, this author, and will communicate any future needs of concerns to the appropriate parties;</p> <p>-No documentation the facility notified the resident's physician, psychiatrist, and/or psychiatric NP.</p> <p>Review of the resident's progress note dated 7/16/24 at 2:06 P.M., and completed by the SSD, showed a care plan meeting was held with the resident to discuss verbal outbursts toward staff and other residents, and explain this is not a good fit for him/her. He/She continues to ask facility to give him/her another chance and he/she continues the same behavior. SSD has been asked to start looking for another facility. He/She gave SSD a few facilities to send his/her referral to.</p> <p>Review of the resident's care plan showed:</p> <p>-On 7/11/24, Observe and anticipate resident's needs: thirst, food, body positioning, pain, toileting needs. Encourage to maintain as much independence and control/decision making as possible. Praise and indication of progress in behaviors;</p> <p>-On 7/29/24, Encourage to take all medications and notify physician of all refusals.</p> <p>Review of the resident's MAR, dated 8/1/24 through 8/31/24, showed:</p> <p>-Behaviors: Verbally aggressive with staff occurred 5 times on the day shift (8/3, 8/4, 8/7, 8/14, and 8/27), and cursing staff occurred 1 time on the evening shift of 8/23;</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Interventions: Encouraged not to speak disrespectfully and/or aggressive to staff on the day shift (8/3, 8/4, 8/7, 8/24, and 8/27), and educated on reasons not to curse at staff on the evening shift of 8/23.</p> <p>Review of the resident's progress notes, dated 8/1/24 through 8/31/24, showed no documentation the facility notified the resident's physician, psychiatrist, and/or the psychiatric NP about the resident's behaviors on 8/3, 8/4, 8/7, 8/14, 8/23, or 8/27/24.</p> <p>Review of the resident's progress note, dated 8/7/24 at 12:00 P.M., showed the resident's physician saw him/her at the facility. No documentation staff updated the physician about the resident's behaviors.</p> <p>Review of the resident's progress note, dated 8/10/24 at 1:20 P.M., completed by the SSD, showed the resident was informed during care plan meeting that was held that the facility was still trying to find him/her another facility, however no one has accepted him/her as of yet. They are still sending referrals out and once a facility had accepted him/her he/she will be informed.</p> <p>Review of the resident's progress note, dated 8/14/24 at 4:03 P.M., showed the resident's physician saw him/her at the facility. No documentation staff updated the physician about the resident's behaviors.</p> <p>Review of the facility Resident Council meeting minutes, dated 8/15/24 at 2:00 P.M., showed:</p> <p>-Staff members present: the former DON, Activity Director (AD) and Activity Aide (AA) F;</p> <p>-18 residents attended, including: Resident #3, Resident #2, and Resident #14;</p> <p>-New Business: discussed Resident #3 was a bully. Always arguing with staff and peers;</p> <p>-There was no facility response to the Resident Council concerns regarding Resident #3's behaviors.</p> <p>Review of the resident's psychiatric note, completed by the psychiatric NP, dated 8/27/24, showed:</p> <p>-Medications: duloxetine HCl 30 MG daily;</p> <p>-Subjective: seen for regular follow-up. He/She was still trying to make the best of his/her situation. Decides he/she does not want any further medication to help him/her from stop flipping out. Denies any symptoms of depression or anxiety at this time;</p> <p>-Objective: engaged with examiner in a cooperative and polite manner. No unusual mannerisms or gestures. Mobility is within normal limits, uses walker at times. The resident was alert and oriented x 3 (person, place, time);</p> <p>-Plan: will follow monthly. Discussed symptoms management. Discussed signs of depression, anxiety, changes in cognition and when to notify staff of symptoms.</p> <p>Review of the resident's MAR, dated 9/1/24 through 9/30/24, showed;</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Willowcreek Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 250 New Florissant Road South Florissant, MO 63031	

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Behaviors:</p> <p>-Verbally aggressive with staff: occurred eight times on the day shift (9/4, 9/5, 9/24, 9/25, 9/26, 9/28, 9/29 and 9/30/24), and four times on the evening shift (9/4, 9/5, 9/20 and 9/30/24);</p> <p>-Disrespectful to staff: occurred one time on the day shift (9/30/24), and one time on the evening shift (9/30/24);</p> <p>-Cursing staff: occurred one time on the day shift (9/30/24), and one time on the evening shift (9/30/24);</p> <p>-Interventions:</p> <p>-Encouraged not to speak disrespectfully and/or aggressive to staff on the day shift (9/4, 9/5, 9/24, 9/25, 9/26, 9/28, 9/29 and 9/30/24), and on the evening shift (9/4, 9/5, 9/20 and 9/30/24);</p> <p>-Educated on reasons not to curse at staff on the day shift (9/30/24) and evening shift (9/30/24);</p> <p>-Encouraged not to curse at staff on the day shift (9/30/24) and evening shift (9/30/24).</p> <p>Review of the resident's medical record, from 9/4/24 through 9/30/24, showed:</p> <p>-No documentation the resident's physician, psychiatrist and/or psychiatric NP were notified of the resident's behaviors after they occurred;</p> <p>-No documentation of SSD or IDT follow-up;</p> <p>-The care plan showed no new interventions/tasks implemented from 9/1/24 through 9/30/24.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <p>-Cognitively intact;</p> <p>-Behavioral Symptoms: Verbal behavioral symptoms directed towards others: behavior not exhibited;</p> <p>-Mobility Device: walker;</p> <p>-Walk 150 feet (ft): once standing the ability to walk at least 150 ft in a corridor or similar space: Supervision or touching assistance, independent.</p> <p>Review of the facility Resident Council meeting minutes, dated 9/20/24 at 10:00 A.M., showed:</p> <p>-Staff members present AD and AA F;</p> <p>-14 residents attended, including: Resident #3, Resident #2, Resident #4, and Resident #14;</p> <p>-Discussed: Activities spoke to Resident #3. He/She promised to stop bothering and cursing out staff and residents;</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Resident Council Follow-Up completed by the former DON and signed on 9/24/24: Spoke to Resident #3 and he/she agreed to do better. Staff will keep watch.</p> <p>Review of the resident's behavior tracking located on the MAR, dated 10/1/24 through 10/31/24, showed:</p> <p>-Behaviors:</p> <p>-Verbally aggressive with staff: occurred 16 times on the day shift (10/8, 10/9, 10/10, 10/12, 10/13, 10/15, 10/16, 10/17, 10/22, 10/23, 10/24 and 10/26/24), and three times on the evening shift (10/23, 10/24 and 10/27/24);</p> <p>-Interventions:</p> <p>-Encouraged not to speak disrespectfully and/or aggressive to staff for all day and evening shift documented behaviors;</p> <p>-No behaviors identified on the evening shift on 10/22/24.</p> <p>Review of the resident's progress notes, from 10/1/24 through 10/31/24, showed:</p> <p>-On 10/22/24 at 7:48 P.M.: the resident noted yelling and cursing in the hallway walking from the front door, stating that they gone have to call the MF police because imma bust that MF down if they don't let me out this MF. They can't hold me no MF in here. They are treating us like we in jail and I've done my time. The resident educated on smoking times and policy. The resident acknowledged teaching, but stated he/she can sign out to smoke. The resident made aware that smoking on the front was prohibited. The resident stated we can't hold him/her hostage and stated his/her sister would be here to pick him/her up. The resident educated on signing out of the facility upon leaving. This nurse also spoke with the resident asking him/her to calm down and stop yelling and using profanity in such an aggressive tone in the hallway around all the other residents. The resident walked away and continued cursing, yelling and using profanity;</p> <p>-No documentation the facility notified the resident's physician, psychiatrist, and/or psychiatric NP;</p> <p>-10/22/24 at 8:27 P.M.: police called related to resident's behaviors. Police arrived and the resident appeared to be calm at this time. The resident continued to have other residents to come to his/her room and after one of the residents asked to leave, Resident #3 followed the other resident to that resident's room after being told it was after hours and resident's roommate are in bed and resting now and visiting was not allowed at this time. The resident stated, MOVE ME. Police called at this time, and arrived and resident calm stating I'm ok, y'all just want me to go off, and he/she walked away. Police stated the resident needs to be sent to the hospital for mental health behaviors and if needed call them back to assist with removing the resident from the facility. Physician called and new orders received to send resident out for behaviors and to follow up with psych immediately;</p> <p>-10/22/24 at 8:38 P.M.: the resident refusing to go to the hospital. Sitting up front at this time stating his/her sister in on his/her way;</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-No documentation the resident's physician was notified the resident refused to go to the hospital for his/her behaviors. No documentation the facility notified the physician the resident refused to go to the hospital as ordered;</p> <p>-10/23/24 at 5:39 P.M.: showed the resident continued to yell out in dining room cursing at staff and using profanity loud and in an intimidating tone to staff. Resident unhappy with meal and states They are feeding me like an animal so I'm going to act like an animal. Resident redirected on using inappropriate language in common areas and around all other residents. This nurse explained to resident this is disrespectful and unacceptable behavior. The resident continued to walk off yelling and using profanity;</p> <p>-No documentation the facility notified the resident's physician, psychiatrist, and/or psychiatric NP;</p> <p>-10/24/24 at 3:00 P.M.: the resident continued to yell, curse and be intimidating to staff and other residents. The resident educated on bullying and reminded that this is inappropriate behavior. The resident redirected and went on down the hall mumbling;</p> <p>-No documentation the resident's physician or psychiatrist/psychiatrist NP was notified;</p> <p>-Review of the resident's progress notes showed no SSD or IDT follow up regarding the resident's 10/22, 10/23, and 10/24/24.</p> <p>-No documentation regarding the resident's behaviors, except on 10/22, 10/23, and 10/24/24.</p> <p>Review of the resident's psychiatric note, completed by the psychiatric NP, dated 10/19/24, showed:</p> <p>-Medications: duloxetine HCl 30 MG daily;</p> <p>-Subjective: seen for regular follow-up. Appears to be very particular, also has a big voice, tall. Asked him/her to not be as intimidating which he/she says he/she is just being him/her;</p> <p>-Objective: met with examiner in a cooperative and polite manner. No unusual mannerisms or gestures. Mobility is within normal limits, uses walker at times. The resident was alert and oriented x 3 (person, place, time);</p> <p>-Plan: will follow monthly. Discussed symptoms management. Discussed signs of depression, anxiety, changes in cognition and when to notify staff of symptoms.</p> <p>Review of the resident's psychiatric NP notes, dated 10/1/24 through 10/31/24, showed:</p> <p>-10/22/24, late evening: Resident having disruptive behavior. Just recently saw the resident and will see on next visit. The resident repeatedly refuses to add additional medications. The resident constantly demanding and disruptive. Is supposed to be going to hospital;</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-10/23/24, evening: Another call, the resident was cussing and being disruptive. The resident refused to go to the hospital the night before. This time it was in the dining room. The resident was cussing at staff and yelling about food he/she doesn't like. Cussed and was loud walking back to room. Resident is very antisocial - hard to redirect. Will see at next visit, but the resident continually denies anything he/she has done and refuses medication changes;</p> <p>-10/24/24, afternoon: Disruptive and inappropriate to staff. Refuses to speak calmly. Will see at next visit, but resident refuses any wrongdoing to me.</p> <p>Further review of the resident's care plan showed no new interventions/tasks regarding the resident's behaviors implemented from 10/1/24 through 10/31/24.</p> <p>Review of the resident's behavior tracking located on the MAR, dated 11/1/24 through 11/30/24, showed;</p> <p>-Behaviors: Verbally aggressive with staff: occurred three times on the day shift (11/5, 11/7, and 11/9/24);</p> <p>-Interventions: Encouraged not to speak disrespectfully and/or aggressive to staff.</p> <p>Review of the resident's medical record from 11/5 through 11/9/24, showed:</p> <p>-No documentation the resident's physician, psychiatrist, and/or psychiatric NP were notified on 11/5, 11/7, or 11/9/24;</p> <p>-No documentation the SSD or IDT followed up regarding the resident's behavior on 11/5, 11/7, or 11/9/24;</p> <p>-The care plan showed the resident was put on a behavior contract on 11/18/24, for being aggressive with a peer.</p> <p>Review of the resident's psychiatric notes, completed by the NP, dated 11/16/24, showed:</p> <p>-Medications: duloxetine HCl 30 mg daily;</p> <p>-Subjective: seen for regular follow-up. Still talking about moving but says no one has found him/her a place. He/She had not been very proactive however in working with the facility, and places they have worked hard to find for him/her, he/she has declined. Denies symptoms of depression or anxiety. Again, tried to discuss medications for his/her mood, but he/she says that he/she did not feel the need, and says he/she was fine. It's everyone else that was messing with him/her. He/She had a large stature with a deep intimidating tone. Again, reminded him/her to try and be mindful towards others. He/She continued to say he/she isn't doing anything wrong;</p> <p>-Plan: will follow monthly. Discussed signs of depression, anxiety, changes in cognition, when to notify staff of symptoms. Discussed symptom management. Practice stress management.</p> <p>Review of the resident's progress notes showed:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-11/16/24 (Saturday) at 8:32 A.M., completed by the Administrator, nurse responded to room after hearing the resident arguing with his/her roommate (Resident #4). Staff immediately separated both residents. The resident's roommate said that Resident #3 pushed his/her chest. Resident #3 denies this. Staff witnessed only arguing, no physical contact. Skin assessment completed. No marks, redness, swelling, or bruising noted. Physician made aware. New order to consult with psychiatrist and send Resident #3 out for psychiatric evaluation. Ambulance and police called to send resident out to psychiatrist evaluation;</p> <p>-11/16/24 at 2:46 P.M.: resident returned from hospital by ambulance. Resident very irate and cursing in the halls. This nurse asked resident to calm down and resident began to curse more. Resident is currently outside in the courtyard threatening to leave against medical advice. Oncoming nurse made aware. Will continue to monitor behavior.</p> <p>Review of the hospital after visit summary from the hospital, dated 11/16/24, showed no new orders.</p> <p>Review of the MAR, showed no documentation of behavior by staff on the day shift of 11/16/24.</p> <p>Review of the resident's progress note's showed:</p> <p>-11/18/24 at 6:48 P.M., documented by the SSD: SSD spoke with resident to see how he/she was feeling since Saturday. He/She stated he/she feels a lot better. He/She was watching TV with his/her friend and seems happy;</p> <p>-11/19/24 at 4:30 P.M., documented by the SSD: SSD spoke with the resident today. He/She was in a pleasant mood. He/She said he/she likes his/her new room and likes that he/she has more space. He/She was feeling much calmer since the incident with the other resident.</p> <p>Review of a Behavior Contract, dated 11/18/24, showed:</p> <p>-Behavior: the resident had a verbal altercation with his/her roommate;</p> <p>-Goals: Resident had agreed to come and speak to staff when there was a concern with another resident and refrain from raising his/her voice to residents and staff;</p> <p>-Date To Be Achieved: 2/18/25;</p> <p>-Resident refused to sign the Behavior Contract;</p> <p>-SSD signed the Behavior Contract 11/18/24.</p> <p>Review of the resident's care plan showed on 11/18/24 the resident was put on a behavior contract for being aggressive with a peer.</p> <p>Review of the facility Resident Council meeting minutes, dated 12/19/24 at 1:30 P.M., showed:</p> <p>-Staff members present: AD and AA F;</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-26 residents attended, including: Resident #2, Resident #4, Resident #7, and Resident #14;</p> <p>-Other Concerns: Residents are complaining about the Resident #3 bullying, cursing all the time, taking their cigarettes and nothing is being done;</p> <p>-No facility response to the Resident Council concerns.</p> <p>Review of the resident's behavior tracking located on the MAR, dated 12/1/24 through 12/31/24, showed no behaviors documented.</p> <p>Review of the resident's psychiatric notes, completed by the NP, dated 12/6/24, showed:</p> <p>-Medications: duloxetine HCl 30 mg daily;</p> <p>-Subjective: he/she denies any actions that are intimidating and always says other people just be messing with him/her;</p> <p>-Discussed medication, as he/she had wanted over the summer, but says he/she was doing fine and just wants to move. The resident was however not helping with this, and he/she was completely able to find placement on his/her own. Appears to want everyone else to do these things, and complains when things aren't done his/her way;</p> <p>-Resident was always calm, polite, pleasant to me, but it always seems like he/she was just telling me what I want to hear and says he/she was always polite to everyone else. This however was not the case as several residents and staff say he/she was at times using foul and loud language;</p> <p>-Objective: The resident's thought content revealed no evidence of delusional ideation, obsessions, or any other preoccupations. The resident was alert and oriented x 3;</p> <p>-Plan: will follow monthly. Discussed signs of depression, anxiety, changes in cognition, when to notify staff of symptoms. Discussed symptom management. Practice stress management.</p> <p>Review of the resident's behavior tracking located on the MAR, dated 1/1/25 through 1/31/25, showed no behaviors documented.</p> <p>Review of the resident's progress note, dated on 1/3/25 at 7:37 P.M., showed the resident causing a disruption on hall. The resident yelling and cursing at staff d</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>22409</p> <p>Based on interview and record review, the facility failed to follow their Abuse Prevention and Prohibition Program policy by failing to promptly and thoroughly investigate one resident's allegation of abuse. Resident #15 alleged an unknown female employee with braids threatened to have his/her brothers come to the facility and whip the resident. The sample size was 16. The census was 120.</p> <p>Review of the facility Abuse Prevention and Prohibition Program policy, revised on 10/24/2022, showed:</p> <ul style="list-style-type: none"> -Purpose: To ensure the Facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements; -Policy: Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property; -The facility is committed to protecting residents from abuse by anyone, including but not limited to Facility Staff, and other residents; -The Administrator is responsible for coordinating and implementing the Facility's abuse prevention policies, procedures, training programs, and systems; -Procedure: The Administrator may delegate coordination and implementation of components of the abuse prevention program to other staff within the Facility; -Investigation: <ul style="list-style-type: none"> -The Facility promptly and thoroughly investigates reports of resident abuse, mistreatment, neglect, injuries of unknown source, or criminal acts; -The Facility has protocols for investigations; -If the Administrator receives a report of an incident or suspected incident of resident abuse, mistreatment, neglect, injuries of unknown source, the Administrator or designee, may appoint a member of the Facility's management team to investigate the alleged incident; -The Facility ensures protection of residents during abuse investigations; <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The Investigator may take some or all of the following steps: Reviews all relevant documentation. Interviews the person(s) making the incident report, any witnesses to the alleged incident, the resident, Facility Staff members who have had contact with the resident during the period of the alleged incident, roommate, other residents to whom the accused employee provides care or services. Reviews all events leading up to the alleged incident. Communicates with the Administrator daily regarding the progress of the investigation. Prepares an investigation report documenting findings of the investigation;</p> <p>-Witness reports must be given in writing and signed and dated;</p> <p>-Resident-to-resident altercations must be reported if the altercation is caused by a willful action that results in physical injury, mental anguish or pain;</p> <p>-The Administrator will submit initial, and follow-up written reports of the results of all abuse investigations and consequent actions to the appropriate agencies;</p> <p>-Protection:</p> <p>-The Facility protects residents from any harm that could result from abuse investigations;</p> <p>-Facility Staff members accused of committing abuse against a resident are suspended until the investigation is complete and the findings have been reviewed by the Administrator;</p> <p>-Staff members alleged to have committed abuse against a resident will not be reinstated to the regular assignment until the abuse investigation is complete and the allegation is unsubstantiated;</p> <p>-If the allegation is regarding resident-resident altercation, the residents will be separated immediately, pending the investigation;</p> <p>-Residents will not be retaliated against for reporting abuse.</p> <p>Review of Resident #15's admission Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 12/20/25, showed:</p> <p>-Hearing/vision: Adequate;</p> <p>-Speech Clarity: Clear speech, distinct intelligible words;</p> <p>-Makes Self Understood: Understood;</p> <p>-Ability To Understand Others: Understands, clear comprehension;</p> <p>-Cognitively intact;</p> <p>-Hallucinations/Delusions: Not exhibited;</p> <p>-Physical, Verbal or Other Behaviors: Not exhibited;</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Diagnoses included: renal (kidney) insufficiency, peripheral vascular disease (build-up of fatty material in the arteries, hardening of the arteries), atrial fibrillation (an abnormal heart rhythm - rapid and irregular), and coronary artery disease (coronary arteries to the heart become narrowed or blocked);</p> <p>-No psychiatric/mood disorders indicated.</p> <p>During an interview on 3/3/25 at 1:45 P.M., the resident said last Wednesday (2/26/25) during the night shift- 11:00 P.M. (Wednesday) to 7:00 A.M. (Thursday) around 3:00 A.M., he/she asked unknown employee (UE) Q if he/she could have some crackers. UE Q went to a different resident's room and asked a second unknown employee (UE R, female with braids) if the resident could have a snack. UE R poked her head out of the room, looked at the resident and said I don't fuck with him/her. I'm going to have my brothers come up and whip his/her ass. UE R said it directly to the resident, and not to UE Q. The resident had seen UE R prior to that happening but had not seen her since. Later that day, the resident went to the Social Service Director's (SSD) office and told her what happened. The SSD had the Administrator and Assistant Director of Nursing (ADON) N come into the office. The resident told all three what had happened. As far as the resident was aware, nothing was done about it. If he/she saw UE R, he/she would be able to identify her. He/She was not afraid of UE R, but when people say something like that you take their word for it. So far, no one had shown up to hurt him/her.</p> <p>During an interview on 3/3/25 at 1:55 P.M., with the Administrator and ADON N, the Administrator said he and ADON N were called into the SSD office last Thursday (his first day at the facility) around 2:00 P.M. The resident told them what he/she had told the surveyor, except that it occurred on the evening shift, not the night shift. By the time they were made aware, the evening shift had started. There were three female staff with braids working. The resident looked at all of them and said it was not UE R. The resident said if he/she saw UE R, he/she would let them know. Although the Administrator started a soft file on the day the resident told them of the alleged allegation, he had not interviewed any other staff or residents about the allegation. The facility would begin their interviewing today. As of today, he had not reviewed the facility's abuse policy. ADON N said the facility had two-night staff that fit the resident's description, Certified Nurse Aid (CNA) O and CNA P. CNA P worked the night shift on 2/26/25. Both CNAs were scheduled to work the night shift on 2/27/25, but both had called off that night. CNA O had not been on the schedule since calling off. CNA O would not be allowed to return until she was interviewed, and the resident had a chance to see her. CNA P worked the night shift on 2/28/25 but had not worked since. CNA P was scheduled to work tonight, but instead would be suspended until she was interviewed, and the resident had a chance to see her. The Administrator said the facility would begin interviewing staff and residents today.</p> <p>Review of the Administrator's soft file on 3/3/25 at 2:55 P.M., showed:</p> <p>-Grievance/Complaint Report;</p> <p>-Name of person filling the grievance/complaint: Resident;</p> <p>-Completed by the SSD on 2/27/25, no time documented;</p> <p>-Date the incident occurred: 2/26/25, time: blank;</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Willowcreek Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 250 New Florissant Road South Florissant, MO 63031	
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Describe the nature of the grievance/complaint: Resident stated the nurse told him/her she don't fuck with him/her, and that she will have her two brothers to come and whoop his/her ass. He/She stated it was on the evening shift. ADON N brought in staff for the resident to look at because he/she said he/she did not know the name. The resident stated he/she knows what the person looks like and he/she will show us when she is here. The resident came back that same evening and said she is not here. The resident could not give a good description of who this person was.</p> <p>During an interview on 3/4/35 at 9:24 A.M., the SSD said the resident came to her office last Thursday on the evening shift. He/She said yesterday (Wednesday) evening after the resident's last smoke time (9:00 P.M. - 9:30 P.M.) he/she was by the nurse's station and a female employee with short braids or dreads said, I don't fuck with him/her and she was going to have her brothers come to the facility to kick his/her ass. The resident did not know the employee's name. The SSD called the Administrator and ADON N into her office immediately because she wanted them to hear what the resident was saying. There were about three CNAs working and the resident said it wasn't any of them. The resident said the unknown employee worked quite a bit. ADON N got the schedule from the evening before, but none of those employees had braids. The Administrator did not give the SSD or the ADON N any directives to initiate an investigation. They would keep a soft file for now and wait to see if the resident could point out the staff person.</p> <p>During an interview on 3/4/25 at 6:40 A.M., Licensed Practical Nurse (LPN) I, who had braids, said she worked with the resident last week. LPN I worked last night, but was not assigned to the resident. The facility did not interview LPN I prior to beginning the shift last night. LPN I was not aware of the resident's allegation. LPN I denied saying that to the resident. At 6:55 A.M., the Administrator walked to the resident's room with LPN I. The resident said LPN I was not the staff member.</p> <p>During an interview on 3/4/25 at 10:00 A.M., the Administrator said the facility investigation was on-going. They should have interviewed LPN I and had the resident look at LPN I prior to the starting work last night to ensure LPN I was not the one. The Administrator was the one who was responsible for investigating abuse and neglect. He did not follow the facility's policy and he should have.</p> <p>MO00250442</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>22409</p> <p>Based on interview and record review, the facility failed to follow their Abuse Prevention and Prohibition policy, by failing to notify the State Survey Agency within two hours after one resident (Resident #15) alleged to the Administrator, Assistant Director of Nursing (ADON) N and the Social Service Director (SSD) on Thursday 2/27/25, that an unknown female employee with braids said she was going to have her brothers come up to the facility and whip the resident's ass. The sample size was 16. The census was 120.</p> <p>Review of the facility's Reporting Abuse policy, undated, showed:</p> <ul style="list-style-type: none"> -Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse 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; -Goods and services that are necessary to avoid physical harm or mental suffering include but are not limited to: The provision of medical care for physical and mental health needs. Protection from malnutrition; -Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation, or withholding of treatment or services; -Mental abuse also includes treatment or actions by anyone in any manner that does not uphold a resident's sense of self-worth and individually dehumanizes the resident and creates an environment that perpetuates a disrespectful and/or potentially abusive attitude toward the resident(s); -Mistreatment means inappropriate treatment or exploitation of a resident; -Neglect means the failure of the facility, it's employees or services providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress; -Verbal abuse means the use of oral, written or gestured languages that willfully includes disparaging and derogatory terms to residents, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to threats of harm and saying things to frighten a resident; -Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. <p>Review of the facility's Abuse Prevention and Prohibition Program policy, revised on 10/24/2022, showed:</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Purpose: To ensure the Facility establishes, operationalizes, and maintains and Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements;</p> <p>-Policy: Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property;</p> <p>-The facility is committed to protecting residents from abuse by anyone, including but not limited to Facility Staff, and other residents;</p> <p>-The Administrator is responsible for coordinating and implementing the Facility's abuse prevention policies, procedures, training programs, and systems;</p> <p>-Reporting/Response:</p> <p>-Facility Staff are Mandatory Reporters;</p> <p>-Facility owners, operators, employees, managers, agents, and contractors are obligated by to report known or suspected instances of abuse;</p> <p>-Administrator, and his/her designee, as Abuse Coordinator: In order to facilitate reporting, ensure confidentiality, and promote order at the Facility, the Administrator, and his/her designee, shall be the individual who reports known or suspected instances of abuse of residents at the Facility to the proper authorities. Facility Staff will report known or suspected instances of abuse to the Administrator, and his/her designee;</p> <p>-The facility will report allegations of abuse, neglect, exploitation and mistreatment immediately, but no later than two hours after forming the suspicion if the alleged violation involves abuse or results in serious bodily injury to the state survey agency. No later than 24 hours after forming suspicion if the alleged violation does not involve abuse and does not result in serious bodily injury to the state survey agency.</p> <p>Review of Resident #15's admission Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 12/20/25, showed:</p> <p>-Hearing/vision: Adequate;</p> <p>-Speech Clarity: Clear speech, distinct intelligible words;</p> <p>-Makes Self Understood: Understood;</p> <p>-Ability To Understand Others: Understands, clear comprehension;</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Cognitively intact;</p> <p>-Hallucinations/Delusions: Not exhibited;</p> <p>-Physical, Verbal or Other Behaviors: Not exhibited;</p> <p>-Diagnoses included: renal (kidney) insufficiency, peripheral vascular disease (build-up of fatty material in the arteries, hardening of the arteries), atrial fibrillation (an abnormal heart rhythm - rapid and irregular), and coronary artery disease (coronary arteries to the heart become narrowed or blocked);</p> <p>-No psychiatric/mood disorders indicated.</p> <p>During an interview on 3/3/25 at 1:45 P.M., the resident said last Wednesday (2/26/25) during the night shift (11:00 P.M. (Wednesday) to 7:00 A.M. (Thursday)) around 3:00 A.M., he/she asked unknown employee (UE) Q if he/she could have some crackers. UE Q went to a different resident's room and asked a second unknown employee (UE R, female with braids) if the resident could have a snack. UE R poked her head out of the room, looked at the resident and said I don't fuck with him/her. I'm going to have my brothers come up and whip his/her ass. UE R said it directly to the resident, and not to UE Q. The resident had seen UE R prior to that happening, but had not seen her since. Later that day, the resident went to the Social Service Director's (SSD) office and told her what happened. The SSD had the Administrator and Assistant Director of Nursing (ADON) N come into the office. The resident told all three what had happened. As far as the resident was aware, nothing was done about it. If he/she saw UE R, he/she would be able to identify her. He/She was not afraid of UE R, but when people say something like that you take their word for it. So far, no one had shown up to hurt him/her.</p> <p>During an interview on 3/3/25 at 1:55 P.M., the Administrator said he and ADON N were called into the SSD's office last Thursday around 2:00 P.M. This was the Administrator's first day. The resident told them what had happened, except the resident said it occurred on the evening shift, not the night shift. By the time they were made aware, the evening shift had started and there were three female employees with braids working. The resident looked at all of them and said it was not them. The Administrator did not contact the Department of Health and Senior Services about the resident's allegation. He had not yet had time to read the facility's policy on abuse reporting. He should have reported the incident per the facility's policy.</p> <p>MO00250442</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22409</p> <p>Based on observation, interview, and record review, the facility failed to provide a behavioral management program for one resident (Resident #3) who frequently yelled, cursed and threatened both residents and staff members. Staff failed to develop and/or implement a care strategy that focused on behavior prevention through on-going Social Service counseling sessions when other options failed. After a behavior occurred, staff failed to closely monitor the resident to ensure the safety of other residents, failed to consistently report behaviors to the physician, and/or psychiatrist/psychiatric Nurse Practitioner (NP) as per policy. The facility failed to ensure Social Services and/or the interdisciplinary team (IDT) consistently followed up on the resident's behaviors in a timely manner. The resident's behaviors triggered one resident's PTSD (post-traumatic stress disorder, a mental health condition that can develop after experiencing or witnessing a traumatic event) and resulted in other residents feeling bullied and intimidated. Residents refused to go to activities or eat in the dining room to avoid being around the resident. The census was 120.</p> <p>The Administrator was notified on 3/3/25 at 11:53 A.M., of an immediate jeopardy (IJ) which began on 1/29/25. The IJ was removed on 1/30/25 as confirmed by surveyor on-site verification.</p> <p>Review of the facility's Behavior-Management policy, undated, showed:</p> <p>-Purpose:</p> <p>-To implement the most desirable and effective interventions to change, modify, decrease, or eliminate behaviors that are distressing to the resident, and/or are decreasing or negatively impacting the resident's quality of life;</p> <p>-To ensure that Facility Staff performs a timely and appropriate assessment of the resident's behavioral symptoms and implement appropriate interventions before and after the resident begins taking psychotherapeutic medications. The facility is responsible for providing behavioral health care and service that create an environment that promotes emotional and psychosocial well-being meet each resident's needs and include individualized approaches to care;</p> <p>-Policy: The concept of behavior management is an interdisciplinary process. The key components of this process are:</p> <p>-a) Identifying residents whose behaviors may pose a risk to self and others;</p> <p>-b) Developing individual and practical care strategies based on assessed needs;</p> <p>-c) Implementing the behavior management program;</p> <p>-d) Ongoing assessment, monitoring, and evaluation of the effectiveness of the behavior management program including the effectiveness of psychoactive drugs;</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The goal of any behavior management process is to maintain function and improve quality of life. The goal of the interdisciplinary team is to promptly identify behavior management issues and develop an effective management program;</p> <p>-It is important to understand that behavior management is not behavior modification. Behavior management means the IDT seeks to accommodate the resident with behavioral problems as much as is practical in the facility;</p> <p>-When a resident displays adverse behavioral symptoms (e.g., crying, yelling, hitting, biting etc.) Licensed Nursing Staff will assess the behavioral symptoms to determine possible causal factors, contact the Attending Physician, and implement non-drug interventions to alleviate the behavioral symptoms before initiating any psychotherapeutic agent(s);</p> <p>-The facility must provide necessary behavioral health care and services which include:</p> <p>-a) Ensuring that the necessary care and services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety;</p> <p>-b) Ensuring that direct care staff interact and communicate in a manner that promotes mental and psychosocial well-being;</p> <p>-c) Providing meaningful activities which promote engagement and positive meaningful relationship between residents and staff, families, other residents and the community. Meaningful activities are those that address the resident's customary routines, interests, preferences, etc. and enhance the resident's well-being;</p> <p>-d) Providing an environment and the atmosphere that is conducive to mental and psychosocial well-being;</p> <p>-Procedure:</p> <p>-I. Assess Causal Factors:</p> <p>A. When a resident exhibits adverse behavioral symptoms (e.g., crying, yelling, hitting, biting etc.), Licensed Nursing Staff will document the behaviors in the medical record, noting the time the behavior(s) occur, antecedent events, possible casual factors and interventions attempted;</p> <p>B. Upon observing the adverse behavioral symptom, staff will do the following as indicated:</p> <p>i. Ensure the safety of the resident as well as all other residents;</p> <p>ii. Document notification of the Attending Physician;</p> <p>iii. Document notification of the resident's family and/or responsible party about the change in behaviors and the Attending Physician's response;</p> <p>iv. Document the incident on the 24-hour report;</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>C. The Charge Nurse will assign a staff members(s) to monitor/shadow the resident as needed;</p> <p>i. Such monitoring is for the protection of the resident as well as all others, and is not meant to restrict their movement or mobility;</p> <p>D. Nursing Staff will continue to monitor the resident's behavior to determine what event(s), if any, precipitated the behavior and document the following information as indicated:</p> <p>i. Date and time of behavior;</p> <p>ii. Location of resident when the behavior occurred;</p> <p>iii. Description of the behavior (e.g., what the resident said or did and if the behavior intensified);</p> <p>iv. Non-verbal cues (e.g., darting eyes may indicate anxiety or fear, crossed arms may signal withdrawal or fear, and tears may indicate sadness, frustration or fear);</p> <p>v. What seemed to cause the behavior;</p> <p>vi. Any interventions used and their effect;</p> <p>E. In assessing the resident for potential causal factors, Licensed Nursing Staff will consider the following factors and document their findings in the medical record;</p> <p>i. Physical conditions (e.g., pain or discomfort, hunger or thirst, fatigue, toileting needs, incontinence);</p> <p>ii. Environmental condition (e.g., inappropriate room temperature, noise, overcrowding);</p> <p>iii. Psychosocial or emotional stressors (e.g., change in resident's customary routine, loneliness, frustration, fear of the unknown, possible abuse by staff or other residents, incompatibility with roommate, inability to communicate needs, lack of support system, loss of control due to changes in physical condition, financial concerns);</p> <p>iv. Medical conditions that require treatment;</p> <p>v. Mental health conditions, which may contribute to resident's behavior;</p> <p>F. It is also important for the facility to use an IDT approach that includes the resident, their family, or resident representative;</p> <p>-II. Implementation of Interventions to Alleviate Possible Causal Factors;</p> <p>A. Possible non-psychotherapeutic drug interventions to consider, include, but are not limited to:</p> <p>i. Physical comfort;</p> <p>(continued on next page)</p>

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Maintaining minutes of all meetings and submitting a copy to the Administrator for review;</p> <p>-A Resident Council response form is utilized to track issues and their resolution;</p> <p>-If the Council raises an issue of concern, the Department responsible for the issue or service is responsible for addressing the item(s) of concern promptly;</p> <p>-The facility will respond in writing to written request or concerns of the resident council in a prompt and timely manner;</p> <p>-The Facility will respond to issues discussed by the Resident Council and may use Resident Council Department Response Form;</p> <p>-The Facility's Quality Assessment & Assurance Committee reviews the Resident Council minutes from the Resident Council as part of its quality review.</p> <p>Review of the facility's Resident Council Follow-Up form, showed: All complaints/concerns identified during resident council will be documented as a grievance on the grievance form. This will include a detailed description of the complaint. It will then be delegated to the appropriate department for resolution. This resolution will be documented on the grievance form as well. A designee will then meet with the resident to discuss the resolution and ensure all parties are satisfied. The completed grievance will then be forwarded to the Administrator for review and approval. These concerns will then be reviewed at the next resident council as Old Business to ensure that concerns have not persisted.</p> <p>Review of the Social Service Director (SSD) job description, undated, showed:</p> <p>-Position Description included: Responsible for identifying psychosocial, mental, and emotional needs along with providing, developing, and/or aiding in the access of services to meet those needs;</p> <p>-Principle Responsibilities:</p> <p>-Plans, organizes, implements, evaluates, and directs a comprehensive Social Services program;</p> <p>-Works with Social Services staff, IDT, and administration to promote and protect resident rights and the psychological well-being of all residents. Prevents and addresses resident/resident abuse;</p> <p>-Maintains accurate and timely documentation;</p> <p>-Participates in the development of a written, interdisciplinary plan of care for each resident that identifies the psychosocial needs/issues of the resident, the goals to be accomplished for those needs/issues, and the appropriate social worker interventions;</p> <p>-Works with the IDT and administration to promote and protect resident rights and the psychological well-being of each resident. Prevent and address resident abuse;</p> <p>-Document progress in meeting the psychosocial needs of residents;</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Willowcreek Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 250 New Florissant Road South Florissant, MO 63031	
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)		
<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Educate nursing personnel regarding the role of the social worker in the facility and the psychosocial needs of the residents;</p> <p>-Provide clinical interventions to address catastrophic events that occur during a resident's stay in the facility.</p> <p>Review of Resident #3's admission face sheet showed:</p> <p>-admitted [DATE];</p> <p>-The resident was listed as his/her own responsible party.</p> <p>Review of the resident's progress notes, located in the electronic health record (EHR), dated 6/6/24 at 12:52 P.M., showed the resident arrived at 12:00 noon, alert and oriented x 4 (person, place, time and situation). Got off ambulance stretcher and walked to room with a steady gait.</p> <p>Review of the Guidelines for Resident Behavior, signed by the resident and co-signed by the SSD on 6/6/24, showed:</p> <p>-Any resident may exhibit problem behaviors, but the intent of the Guidelines is to address the volitional (done intentionally, not by accident) of those individuals who have the capacity to understand the consequences of their behaviors;</p> <p>-Resident Compliance: admission to a facility is based on a resident's need for care. A resident's compliance with his/her plan of care and cooperation with staff during the stay in the facility is encouraged;</p> <p>-General Conduct: residents are expected to treat staff, other residents with respect, dignity and privacy. Conduct must be consistent with accepted community standards, local, federal and state laws. Unacceptable conduct includes but is not limited to: physical abuse, verbal abuse. This conduct is not permitted on or about the facility;</p> <p>-Non-Compliance: if we determine that residents' behavior is contrary to these rules and is compromising their health care or that of other residents, these residents will be subject to administrative actions. Failure to comply with these rules may result in the initiation of the following administrative actions:</p> <p>A. The initiation of a Behavioral Management Plan between the resident and the facility. A Behavioral Management Plan should be developed under the guidance of trained professionals;</p> <p>B. Referral to local law enforcement agency;</p> <p>C. Discharge from the facility when the violations meet the thresholds of state and federal regulations (for example, if the violations are a danger to the resident or others).</p> <p>Review of the resident's care plan, located in the EHR, showed:</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Problem, 6/6/24: Resident has a mood problem, depression. Goal: Resident will not experience any increase in signs and symptoms of mood disturbance. Interventions/Tasks: Administer medications as ordered. Behavioral health consult as needed. Communicate with resident regarding mood state and treatment. Encourage resident to express feelings. Encourage resident to participate in activities of choice. Encourage to maintain as much independence and control/decision making as possible. Notify medical provider of increased episodes of mood disturbance;</p> <p>-Problem, 6/13/24: Resident has a behavior problem. Resident was noted to speak rudely to roommate, eating off other residents' plates, verbally aggressive with staff, disrespectful to staff;</p> <p>-Goal: resident will have fewer episodes of behaviors through review date. Interventions/Tasks (6/13/24);</p> <p>-Approach, speak in calm manner. Behavioral health consults as needed. Communicate with resident regarding behaviors and treatment. Consult with Pastoral care, Psych services, and/or support groups. Minimize potential for behaviors by offering tasks that divert attention. Monitor behavioral episodes and attempt to determine underlying causes. Intervene as necessary to protect the rights and safety of others. Encourage not to curse or speak disrespectfully and/or aggressive to staff. Notify medical provider of increased episodes of behaviors. 6/14/24: Encouraged to speak to roommate respectfully and encouraged not to eat off of other resident's plates.</p> <p>Review of the resident's record showed there was no behavior management program or ongoing assessment, monitoring, and evaluation of the effectiveness of the behavior management program including the effectiveness of psychoactive drugs documented.</p> <p>Review of the resident's progress note, dated 6/12/24 at 2:26 P.M., showed the resident's physician saw the resident at the facility.</p> <p>Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/13/24, showed:</p> <p>-Speech Clarity: Clear speech, distinct intelligible words;</p> <p>-Makes Self Understood: ability to express ideas and wants: understood;</p> <p>-Ability To Understand Others: understood;</p> <p>-Cognitively intact;</p> <p>-Behavioral Symptoms: Verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others): behavior not exhibited;</p> <p>-Mobility Devices: walker;</p> <p>-Walk 150 feet (ft): once standing the ability to walk at least 150 ft in a corridor or similar space: supervision or touching assistance, helper provides verbal cues or touching/steadying assistance as resident completes activity;</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Diagnoses of high blood pressure, diabetes mellitus (high blood sugar) and depression.</p> <p>Review of the resident's medication administration record (MAR, a form where nurse documents medication administration and behavioral episodes) dated 6/6/24 through 6/30/24, located in the EHR, showed:</p> <p>-6/6/24: Duloxetine HCl (antidepressant) 30 milligrams (mg) daily;</p> <p>-Behaviors: Verbally aggressive with staff: occurred 1 time on the evening shift (6/13/24);</p> <p>-Interventions: Encouraged not to speak disrespectfully and/or aggressive to staff on the evening shift (6/13/24);</p> <p>Review of the resident's progress notes, dated 6/13/24, showed no documentation the facility notified the resident's physician, psychiatrist, and/or the psychiatric NP about the resident's behavior on the evening shift of 6/13/24.</p> <p>Review of the resident's progress note, on 6/14/24 at 12:07 P.M., showed the SSD wrote the resident said he/she was here short term and was just waiting on his/her apartment to be approved. Resident rights were reviewed including the facility guidelines for behavior, drugs, and smoking.</p> <p>Review of the resident's MAR, dated 7/1/24 through 7/31/24, showed no behaviors documented.</p> <p>Review of the resident's progress note, dated 7/3/24 at 6:59 P.M., showed:</p> <p>-Resident had verbal disagreement with another resident, nursing staff present at the time, no contact made. Resident separated from the other resident. Resident was calm sitting outside in the smoking area listening to music;</p> <p>-No SSD or IDT follow-up documented.</p> <p>Review of the resident's psychiatric note, completed by the psychiatric NP, dated 7/10/24, showed:</p> <p>-Diagnoses: post-traumatic stress disorder (a mental health disorder that can develop after witnessing a traumatic event), nicotine dependence, cocaine use (in remission), other specific personality disorders, and persistent mood disorder;</p> <p>-Medications: duloxetine HCl 30 MG daily;</p> <p>-Subjective: seen for regular follow-up, says he/she was still trying to make the best of his/her situation. Decides he/she does not want medication to help him/her stop flipping out. Discussed trying to stay calm and walking away from conflict, which I am not sure he/she was completely on board with. Denies symptoms of depression or anxiety. Just mood swings he/she says;</p> <p>-Objective: resident was engaged with examiner in a cooperative and polite manner. Mobility was within normal limits. Stream of mental activity was logical, relevant, coherent, and goal directed;</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Plan: will follow monthly. Discussed symptoms management. Discussed signs of depression, anxiety, changes in cognition and when to notify staff of symptoms.</p> <p>Review of the resident's progress notes showed:</p> <p>-7/11/24 at 6:22 A.M.: the resident had a verbal altercation with roommate. Resident was loud, disturbing, and using profane language. The resident slammed the door behind roommate;</p> <p>-7/11/24 at 10:29 A.M., IDT note (Administrator, former Director of Nursing (DON), SSD and Nursing Manager): verbal disagreement with roommate. The resident called roommate a racial slur. Roommate did not like this and told the resident so. The resident became upset when staff intervened. The resident left the room shutting the door loudly. The resident educated to be considerate of others feelings and preferences. The resident verbalized understanding;</p> <p>-7/11/24 at 3:04 P.M., completed by the SSD: spoke with the resident about his/her disagreement with roommate this morning. He/She said he/she closed the door but did not mean to slam it. Explained to him/her if he/she has a problem with his/her roommate just come and speak to them. Also spoke about changing rooms. He/She said he/she was happy with that;</p> <p>-7/13/24 at 11:17 A.M., documented by the Administrator: met with resident for psychosocial follow-up. Said he/she likes his/her new room and new roommates. Reinforced with resident that he/she must remain respectful with facility staff. Said he/she understands and was working on it. He/She feels that due to his/her size, he/she may come across as more upset than he/she actually was. Reeducated that he/she can bring any concerns to facility management, social service, this author, and will communicate any future needs of concerns to the appropriate parties;</p> <p>-No documentation the facility notified the resident's physician, psychiatrist, and/or psychiatric NP.</p> <p>Review of a Behavior Contract, dated 7/16/24, showed:</p> <p>-Behavior: resident has had several verbal outbursts with staff;</p> <p>-Goal (must be measurable): resident will learn to stop with the verbal outburst and speak in a calm manner. If this behavior continues, resident can be at risk for discharge from facility;</p> <p>-Date To Be Achieved: 10/16/24;</p> <p>-SSD signed the Behavior Contract on 7/16/24;</p> <p>-Resident refused to sign the contract.</p> <p>Review of the resident's progress note dated 7/16/24 at 2:06 P.M., and completed by the SSD, showed a care plan meeting was held with the resident to discuss verbal outbursts toward staff and other residents, and explain this is not a good fit for him/her. He/She continues to ask facility to give him/her another chance and he/she continues the same behavior. SSD has been asked to start looking for another facility. He/She gave SSD a few facilities to send his/her referral to.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the resident's care plan showed:</p> <p>-On 7/11/24, Observe and anticipate resident's needs: thirst, food, body positioning, pain, toileting needs. Encourage to maintain as much independence and control/decision making as possible. Praise and indication of progress in behaviors;</p> <p>-On 7/29/24, Encourage to take all medications and notify physician of all refusals.</p> <p>Review of the resident's MAR, dated 8/1/24 through 8/31/24, showed:</p> <p>-Behaviors: Verbally aggressive with staff occurred 5 times on the day shift (8/3, 8/4, 8/7, 8/14, and 8/27), and cursing staff occurred 1 time on the evening shift of 8/23;</p> <p>-Interventions: Encouraged not to speak disrespectfully and/or aggressive to staff on the day shift (8/3, 8/4, 8/7, 8/24, and 8/27), and educated on reasons not to curse at staff on the evening shift of 8/23.</p> <p>Review of the resident's progress notes, dated 8/1/24 - 8/31/24, showed no documentation the facility notified the resident's physician, psychiatrist, and/or the psychiatric NP about the resident's behaviors on 8/3, 8/4, 8/7, 8/14, 8/23, or 8/27/24.</p> <p>Review of the resident's progress note, dated 8/7/24 at 12:00 P.M., showed the resident's physician saw him/her at the facility. No documentation staff updated the physician about the resident's behaviors.</p> <p>Review of the resident's progress note, dated 8/10/24 at 1:20 P.M., completed by the SSD, showed the resident was informed during care plan meeting that was held that the facility was still trying to find him/her another facility, however no one has accepted him/her as of yet. They are still sending referrals out and once a facility had accepted him/her he/she will be informed.</p> <p>Review of the resident's progress note, dated 8/14/24 at 4:03 P.M., showed the resident's physician saw him/her at the facility. No documentation staff updated the physician about the resident's behaviors.</p> <p>Review of the facility Resident Council meeting minutes, dated 8/15/24 at 2:00 P.M., showed:</p> <p>-Staff members present: the former DON, Activity Director (AD) and Activity Aide (AA) F;</p> <p>-18 residents attended, including: Resident #3, Resident #2, and Resident #14;</p> <p>-New Business: discussed Resident #3 was a bully. Always arguing with staff and peers;</p> <p>-There was no facility response to the Resident Council concerns regarding Resident #3's behaviors.</p> <p>Review of the resident's psychiatric note, completed by the psychiatric NP, dated 8/27/24, showed:</p> <p>-Medications: duloxetine HCl 30 MG daily;</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Subjective: seen for regular follow-up. He/She was still trying to make the best of his/her situation. Decides he/she does not want any further medication to help him/her from stop flipping out. Denies any symptoms of depression or anxiety at this time;</p> <p>-Objective: engaged with examiner in a cooperative and polite manner. No unusual mannerisms or gestures. Mobility is within normal limits, uses walker at times. The resident was alert and oriented x 3 (person, place, time);</p> <p>-Plan: will follow monthly. Discussed symptoms management. Discussed signs of depression, anxiety, changes in cognition and when to notify staff of symptoms.</p> <p>Review of the resident's MAR, dated 9/1/24 through 9/30/24, showed;</p> <p>-Behaviors:</p> <p>-Verbally aggressive with staff: occurred eight times on the day shift (9/4, 9/5, 9/24, 9/25, 9/26, 9/28, 9/29 and 9/30/24), and four times on the evening shift (9/4, 9/5, 9/20 and 9/30/24);</p> <p>-Disrespectful to staff: occurred one time on the day shift (9/30/24), and one time on the evening shift (9/30/24);</p> <p>-Cursing staff: occurred one time on the day shift (9/30/24), and one time on the evening shift (9/30/24);</p> <p>-Interventions:</p> <p>-Encouraged not to speak disrespectfully and/or aggressive to staff on the day shift (9/4, 9/5, 9/24, 9/25, 9/26, 9/28, 9/29 and 9/30/24), and on the evening shift (9/4, 9/5, 9/20 and 9/30/24);</p> <p>-Educated on reasons not to curse at staff on the day shift (9/30/24) and evening shift (9/30/24);</p> <p>-Encouraged not to curse at staff on the day shift (9/30/24) and evening shift (9/30/24).</p> <p>Review of the resident's medical record, from 9/4/24 through 9/30/24, showed:</p> <p>-No documentation the resident's physician, psychiatrist and/or psychiatric NP were notified of the resident's behaviors after they occurred;</p> <p>-No documentation of SSD or IDT follow-up;</p> <p>-The care plan showed no new interventions/tasks implemented from 9/1/24 through 9/30/24.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <p>-Cognitively intact;</p> <p>-Behavioral Symptoms: Verbal behavioral symptoms directed towards others: behavior not exhibited;</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Mobility Device: walker;</p> <p>-Walk 150 feet (ft): once standing the ability to walk at least 150 ft in a corridor or similar space: Supervision or touching assistance, independent.</p> <p>Review of the facility Resident Council meeting minutes, dated 9/20/24 at 10:00 A.M., showed:</p> <p>-Staff members present AD and AA F;</p> <p>-14 residents attended, including: Resident #3, Resident #2, Resident #4, and Resident #14;</p> <p>-Discussed: Activities spoke to Resident #3. He/She promised to stop bothering and cursing out staff and residents;</p> <p>-Resident Council Follow-Up completed by the former DON and signed on 9/24/24: Spoke to Resident #3 and he/she agreed to do better. Staff will keep watch.</p> <p>Review of the resident's behavior tracking located on the MAR, dated 10/1/24 through 10/31/24, showed;</p> <p>-Behaviors:</p> <p>-Verbally aggressive with staff: occurred 16 times on the day shift (10/8, 10/9, 10/10, 10/12, 10/13, 10/15, 10/16, 10/17, 10/22, 10/23, 10/24 and 10/26/24), and three times on the evening shift (10/23, 10/24 and 10/27/24);</p> <p>-Interventions:</p> <p>-Encouraged not to speak disrespectfully and/or aggressive to staff for all day and evening shift documented behaviors;</p> <p>-No behaviors identified on the evening shift on 10/22/24.</p> <p>Review of the resident's progress notes, from 10/1/24 through 10/31/24, showed:</p> <p>-On 10/22/24 at 7:48 P.M.: the resident noted yelling and cursing in the hallway walking from the front door, stating that they gone have to call the MF police because imma bust that MF down if they don't let me out this MF. They can't hold me no MF in here. They are treating us like we in jail and I've done my time. The resident educated on smoking times and policy. The resident acknowledged teaching, but stated he/she can sign out to smoke. The resident made aware that smoking on the front was prohibited. The resident stated we can't hold him/her hostage and stated his/her sister would be here to pick him/her up. The resident educated on signing out of the facility upon leaving. This nurse also spoke with the resident asking him/her to calm down and stop yelling and using profanity in such an aggressive tone in the hallway around all the other residents. The resident walked away and continued cursing, yelling and using profanity;</p> <p>-No documentation the facility notified the resident's physician, psychiatrist, and/or psychiatric NP;</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-10/22/24 at 8:27 P.M.: police called related to resident's behaviors. Police arrived and the resident appeared to be calm at this time. The resident continued to have other residents to come to his/her room and after one of the residents asked to leave, Resident #3 followed the other resident to that resident's room after being told it was after hours and resident's roommate are in bed and resting now and visiting was not allowed at this time. The resident stated, MOVE ME. Police called at this time, and arrived and resident calm stating I'm ok, y'all just want me to go off, and he/she walked away. Police stated the resident needs to be sent to the hospital for mental health behaviors and if needed call them back to assist with removing the resident from the facility. Physician called and new orders received to send resident out for behaviors and to follow up with psych immediately;</p> <p>-10/22/24 at 8:38 P.M.: the resident refusing to go to the hospital. Sitting up front at this time stating his/her sister in on his/her way;</p> <p>-No documentation the resident's physician was notified the resident refused to go to the hospital for his/her behaviors. No documentation the facility notified the physician the resident refused to go to the hospital as ordered;</p> <p>-10/23/24 at 5:39 P.M.: showed the resident continued to yell out in dining room cursing at staff and using profanity loud and in an intimidating tone to staff. Resident unhappy with meal and states They are feeding me like an animal so I'm going to act like an animal. Resident redirected on using inappropriate language in common areas and around all other residents. This nurse explained to resident this is disrespectful and unacceptable behavior. The resident continued to walk off yelling and using profanity;</p> <p>-No documentation the facility notified the resident's physician, psychiatrist, and/or psychiatric NP;</p> <p>-10/24/24 at 3:00 P.M.: the resident continued to yell, curse and be intimidating to staff and other residents. The resident educated on bullying and reminded that this is inappropriate behavior. The resident redirected and went on down the hall mumbling;</p> <p>-No documentation the resident's physician or psychiatrist/psychiatrist NP was notified;</p> <p>-Review of the resident's progress notes showed no SSD or IDT follow up regarding the resident's 10/22, 10/23, and 10/24/24.</p> <p>-No documentation regarding the resident's behaviors, except on 10/22, 10/23, and 10/24/24.</p> <p>Review of the resident's psychiatric note, completed by the psychiatric NP, dated 10/19/24, showed:</p> <p>-Medications: duloxetine HCl 30 MG daily;</p> <p>-Subjective: seen for regular follow-up. Appears to be very particular, also has a big voice, tall. Asked him/her to not be as intimidating which he/she says he/she is just being him/her;</p> <p>-Objective: met with examiner in a cooperative and polite manner. No unusual mannerisms or gestures. Mobility is within normal limits, uses walker at times. The resident was alert and oriented x 3 (person, place, time);</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Plan: will follow monthly. Discussed symptoms management. Discussed signs of depression, anxiety, changes in cognition and when to notify staff of symptoms.</p> <p>Review of the resident's psychiatric NP notes, dated 10/1/24 through 10/31/24, showed:</p> <p>-10/22/24, late evening: Resident having disruptive behavior. Just recently saw the resident and will see on next visit. The resident repeatedly refuses to add additional medications. The resident constantly demanding and disruptive</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265607	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Willowcreek Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 250 New Florissant Road South Florissant, MO 63031	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>22409</p> <p>Based on interview and record review, the facility failed to follow their Quality Assessment & Assurance (QAA) Program policy by failing to provide ongoing monitoring and evaluation of one resident (Resident #3) with frequent disruptive verbal behaviors that affected both staff and residents. The facility provided their last four (September, October, November and December 2024) Quality Assessment and Assurance Committee's meeting minutes. Although the resident's behaviors were ongoing during those four months, the facility was only able to provide documented evidence the resident's behaviors had been addressed for two of those four months, September and December 2024. The census was 120.</p> <p>Review of the facility Quality Assessment & Assurance Program policy, revised on 6/2020, showed:</p> <ul style="list-style-type: none"> -Purpose: To ensure that all services provided by the facility to residents meet the level of quality as required; -Policy: This facility implements and maintains an ongoing, Facility-wide Quality Assurance and Performance Improvement Program (QAPI) designed to monitor and evaluate the quality of resident care, pursue methods to improve care quality, and resolve identified problems; -Procedure/Goal: <ul style="list-style-type: none"> -To provide a means to identify and resolve present and potential negative outcomes related to resident care and safety; -To reinforce and build upon effective systems of services and positive care measures; -To provide a structure and process to correct identified quality deficiencies; -To establish and implement plans to correct deficiencies, and to monitor the effects of these action plans on resident outcome; -To help departments, consultants, and ancillary services that provide direct or indirect care to residents to communicate effectively, and to delineate lines of authority, responsibility, and accountability; -To establish a system and process to maintain documentation relative to the QAPI Program, as a basis for demonstrating that there is an effective ongoing program; -Authority: <ul style="list-style-type: none"> -The Administrator is responsible for ensuring that the Facility's QAPI Program complies with local, state, and federal regulator agency requirements; -Implementation <p>(continued on next page)</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Focus: The following areas are monitored for quality and appropriateness of resident care, and any trends in performance and outcomes:</p> <p>-Resident Rights;</p> <p>-Resident Behavior and Facility Practices.</p> <p>Review of Resident #3's care plan, showed:</p> <p>-Problem, 6/6/24: Resident has a mood problem, depression;</p> <p>-Goal: Resident will not experience any increase in signs and symptoms of mood disturbance;</p> <p>-Interventions/Tasks: Administer medications as ordered. Behavioral health consult as needed. Communicate with resident regarding mood state and treatment. Encourage resident to express feelings. Encourage resident to participate in activities of choice. Encourage to maintain as much independence and control/decision making as possible. Notify medical provider of increased episodes of mood disturbance;</p> <p>-Problem, 6/13/24: resident has a behavior problem. Resident was noted to speak rudely to roommate, eating off other residents' plates, verbally aggressive with staff, disrespectful to staff. 11/18/24: Resident was put on a behavior contract for being aggressive with a peer;</p> <p>-Goal: resident will have fewer episodes of behaviors;</p> <p>-Interventions/Tasks (6/13/24): approach, speak in calm manner. Behavioral health consults as needed. Communicate with resident regarding behaviors and treatment. Consult with Pastoral care, Psych services, and/or support groups. Minimize potential for behaviors by offering tasks that divert attention. Monitor behavioral episodes and attempt to determine underlying causes. Intervene as necessary to protect the rights and safety of others. Encourage not to curse or speak disrespectfully and/or aggressive to staff. Notify medical provider of increased episodes of behaviors. 6/14/24: Encouraged to speak to roommate respectfully and encouraged not to eat off of other resident's plates. 7/11/24: Observe and anticipate resident's needs: thirst, food, body positioning, pain, toileting needs. Encourage to maintain as much independence and control/decision making as possible. Praise and indication of progress in behaviors. 7/29/24: Encourage to take all medications and notify physician of all refusals. 8/8/24 and revised 10/7/24: care plan meeting held with the interdisciplinary team.</p> <p>Review of the resident's quarterly minimum data set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/13/24, showed:</p> <p>-Speech Clarity: Clear speech, distinct intelligible words;</p> <p>-Makes Self Understood: ability to express ideas and wants: understood;</p> <p>-Ability To Understand Others: understood;</p> <p>-Cognitively intact;</p> <p>-Behavioral Symptoms: Verbal behavioral symptoms directed towards others: behavior not exhibited;</p> <p>(continued on next page)</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Diagnoses of high blood pressure, diabetes mellitus (high blood sugar) and depression.</p> <p>Review of the facility Resident Council meeting minutes, dated 8/15/24 at 2:00 P.M., showed:</p> <p>-Staff members present: the former Director of Nursing (DON), Activity Director (AD) and Activity Aide (AA) F;</p> <p>-18 residents attended, including: Resident #3, Resident #2, and Resident #14;</p> <p>-New Business: Discussed Resident #3 is a bully. Always arguing with staff and peers;</p> <p>Review of the resident's medication administration record (MAR), dated 9/1/24 through 9/30/24, showed:</p> <p>-Behaviors:</p> <p>-Verbally aggressive with staff: occurred 8 times on the day shift (9/4, 9/5, 9/24, 9/25, 9/26, 9/28, 9/29 and 9/30/24), and four times on the evening shift (9/4, 9/5, 9/20 and 9/30/24);</p> <p>-Disrespectful to staff: occurred one time on the day shift (9/30/24), and one time on the evening shift (9/30);</p> <p>-Cursing staff: occurred one time on the day shift (9/30/24), and one time on the evening shift (9/30/24).</p> <p>Review of the facility's QAA Committee minutes of meeting, dated 9/25/25, showed:</p> <p>--Attendees: Administrator, former DON, Medical Director (MD), MDS Coordinator, Maintenance Director, AD, Social Services Director (SSD), Dietary Manager (DM);</p> <p>-Social Services:</p> <p>-Committee Recommendations: Staff and residents' complaints of Resident #3 being disrespectful;</p> <p>-Action Taken: Met with resident again about behaviors;</p> <p>-Follow-up on Action Taken: Pending placement, working with apartment. Psychiatric Nurse Practitioner to see;</p> <p>Review of the resident's behavior tracking located on the MAR, dated 10/1/24 through 10/31/24, showed: Behaviors: Verbally aggressive with staff: occurred 16 times on the day shift (10/8, 10/9, 10/10, 10/12, 10/13, 10/15, 10/16, 10/17, 10/22, 10/23, 10/24 and 10/26/24), and three times on the evening shift (10/23, 10/24 and 10/27).</p> <p>Review of the facility's QAA Committee minutes of meeting, dated 10/30/25, showed:</p> <p>-Attendees: Administrator, former DON, MD, MDS Coordinator, Maintenance Director, AD, SSD and DM;</p> <p>(continued on next page)</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-No documentation regarding Resident #3.</p> <p>Review of the resident's behavior tracking located on the MAR, dated 11/1/24 through 11/30/24, showed: Behaviors: Verbally aggressive with staff: occurred three times on the day shift (11/5, 11/7 and 11/9/24).</p> <p>Review of the facility QAA Committee minutes of meeting, dated 11/4/2024, showed:</p> <p>-Attendees: Administrator, former DON, MD, MDS Coordinator, Maintenance Director, AD, SSD and DM;</p> <p>-No documentation regarding Resident #3.</p> <p>Review of the facility QAA Committee minutes of meeting, dated 12/18/2024, showed:</p> <p>-Attendees: Administrator, former DON, MD, MDS Coordinator, Maintenance Director, AD, SSD and DM;</p> <p>-Committee Recommendations: Resident #3. Resident to resident altercation reviewed. Behavior contract not signed. Residents/staff complain resident is disruptive;</p> <p>-Action Taken: Reevaluate current plan. Working on further immediate placement options.</p> <p>Review of the facility Resident Council meeting minutes, dated 12/19/24 at 1:30 P.M., showed:</p> <p>-Staff members present: AD and AA F;</p> <p>-26 residents attended, including: Resident #2, Resident #4, Resident #7, and Resident #14;</p> <p>-Other Concerns: Residents are complaining about the Resident #3 bullying, cursing all the time, taking their cigarettes and nothing is being done;</p> <p>-No facility response to the Resident Council concerns.</p> <p>During an interview on 1/29/24 at 12:30 P.M., the Administrator said the facility Quality Assessment & Assurance Program policy was current and should be followed. Resident #3 had had on-going disruptive behaviors effecting both staff and residents. Although the QAA Committee discussed the resident's behaviors during their meetings on 10/35/24, and 11/4/24, she was unable to provide documentation the committee had addressed the resident's behaviors.</p>