

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 05/13/2025
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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>Based on interview and record review, the facility failed to follow their grievance policy to maintain an effective grievance process for residents to voice grievances and promptly resolve them for one resident who voiced a grievance over staff treatment (Resident #1). The facility failed to take immediate action to prevent further potential violations of any resident rights while the grievance was being investigated. The facility failed to provide a summary of the pertinent findings including whether the grievance was confirmed and failed to follow up with the resident to inform him/her of the findings of the investigation and any corrective actions recommended in a timely manner. The facility also failed to ask the resident if he/she was satisfied with the outcome of the results of the investigation. The failures had the potential to affect all residents. The sample size was 4. The facility census was 115.</p> <p>Review of the facility's Grievance/Missing Property policy, revised 8/2020, showed:</p> <ul style="list-style-type: none"> -Purpose: To ensure that residents, family members, and representatives know about the procedure for filing grievances and complaints; -Policy: The facility advises residents and their representatives (including family, legal representatives and advocates) of their right to file grievances without discrimination or reprisal, and of the process for filing grievances or complaints. The facility ensures that there is no retaliation for filing a grievance or complaint and ensures that there is a prompt review, investigation and response to and resolution of grievances and complaints. The disposition of all resident grievances and/or complaints is recorded in the facility's resident grievance/compliant log; -Duties and obligations of staff: All alleged abuse, mistreatment, neglect, injuries of unknown source, and misappropriation of property will be reported to the Administrator immediately; -Designation of Grievance Official: The facility will identify a Grievance Official who is responsible for: <ul style="list-style-type: none"> -Overseeing the grievance process; -Receiving and tracking grievances through to their conclusion; -Leading any necessary investigations by the facility; -Issuing written grievance decisions to the resident; and <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
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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Coordinating with state and federal agencies as necessary for specific allegations;</p> <p>-Grievance investigation: Upon receiving a resident grievance/complaint form, the Grievance Official or designee begins an investigation into the allegations. The Grievance Official will take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated. The department director of an involved employee is notified of the nature of the complaint and that an investigation is underway;</p> <p>-The investigation and report include, as applicable:</p> <p>-The date and time the grievance was received;</p> <p>-The date and time of the alleged incident;</p> <p>-The circumstances surrounding the alleged incident;</p> <p>-The location of the alleged incident;</p> <p>-Steps taken to investigate the grievance;</p> <p>-The resident's account of the alleged incident;</p> <p>-The employee's account of the alleged incident;</p> <p>-Accounts of any other individuals involved (i.e., employee's supervisor, etc.);</p> <p>-Summary of the pertinent findings including whether the grievance was confirmed or not confirmed;</p> <p>-Recommendations for corrective action; and</p> <p>-Date the written grievance was issued;</p> <p>-The Administrator will be provided with a completed resident grievance/complaint investigation report within five (5) working days of the incident utilizing facility specific forms;</p> <p>-If follow-up is required, the Administrator is responsible for ensuring that the follow-up action is taken in a timely manner;</p> <p>-The Administrator/designee will maintain copies of resident grievance investigation reports for no less than 3 years from the issuance of the grievance decision;</p> <p>-The facility will inform the resident or his or her representative or concerned party of the findings of the investigation and any corrective actions recommended in a timely manner;</p> <p>-If the resident is not satisfied with the result of the investigation, or the recommended actions, he or she may file a written complaint to the local Long-Term Care Ombudsman's office or to the state department.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's March 2025 grievance concern log, showed no grievance concern documented for Resident #1.</p> <p>Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/4/25, showed:</p> <ul style="list-style-type: none"> -Cognitively intact; -Upper extremity impairment on one side; -Wheelchair; -Diagnoses included, anemia (lower than normal red blood cells or hemoglobin) and renal insufficiency (a condition where the kidneys don't function as well as they should). <p>Review of the resident's grievance/complaint report, dated 3/5/25, showed:</p> <ul style="list-style-type: none"> -Describe the nature of the grievance/complaint (be specific): -The resident said that a Certified Nurses Aide (CNA) slammed him/her into the restroom. CNA A wanted him/her to stand up. He/She told CNA A he/she needed the lift. CNA A slammed his/her leg against the resident's foot to get him/her off the toilet; -Signed 3/5/25 by Social Service Director (SSD); -For office use only: -Date: blank; -Received by: blank; -Title: blank. <p>Review of the facility's grievance investigation, showed:</p> <ul style="list-style-type: none"> -CNA A's statement, signed, and no date; -To whom this may concern, please accept this statement regarding the incident that happened on 3/1/25, night shift. In brief, Certified Nurse Assistant (CNA) A helped the resident to the bathroom with the sit to stand (mechanical lift). The resident had a bowel movement. CNA A cleaned the resident up and put him/her back into his/her chair with the sit to stand. Staff met at the resident's room and CNA A put him/her back in bed using the sit to stand; -Review of the facility's corrective action memo, dated 3/5/25, showed; -Employee: CNA A; -Acting Director of Nursing (ADON): Supervisor; <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Late Entry-Social Service note, dated 3/5/25 at 5:23 A.M., the Social Worker, Executive Director and the Assistant Director of Nursing (ADON) met with the resident to see what happened to him/her, and he/she was upset with the way he/she was being transferred. It was explained to him/her that the facility will start an investigation, and the facility wanted him/her to be safe and be comfortable;</p> <p>-Social Services note, dated 3/6/25 at 7:29 P.M., Social Worker spoke with the resident to see how he/she was doing and he/she stated he/she was fine. The resident told what the nurse did yesterday and that some x-rays were ordered. He/She was asked if he/she felt safe at the facility. He/She felt safe;</p> <p>-No nursing documentation of the alleged incident prior to or after the Social Service note.</p> <p>Review of the resident's progress notes, showed:</p> <p>-Social Service note, dated 3/7/25 at 12:39 P.M., Social Worker spoke with the resident to see how he/she was doing today. The resident said his/her shoulder was bothering him/her from the incident the other day. He/She would like to get it checked out. The Charge Nurse and ADON were notified;</p> <p>-General progress note, dated 3/7/25 at 4:21 P.M., the resident reported to the Social Worker that right upper extremity (RUE) was painful due to incident days prior. Medical Director (MD) made aware. New x-ray orders received.</p> <p>During an interview on 5/12/25 at 10:25 A.M., the resident said he/she wanted to use the restroom and asked for help getting to the bathroom. CNA A brought the lift to his/her room. He/She said the aide told him/her to stand up. He/She told CNA A he/she was tired, but CNA A insisted. The resident stood up because he/she did not want to argue. The resident got weak while standing. CNA A stomped on both the resident's feet, trying to hurry him/her up to sit on the toilet. The resident was getting weaker. CNA A pushed him/her down on the toilet. The resident tried to brace himself/herself for the fall. He/She fell back hard and hurt his/her back. The resident demonstrated to the surveyor how he/she tried to brace himself/herself. The resident stretched out his/her arms slightly behind him/her with open hands. The resident told CNA A that was abuse. The resident asked the CNA if he/she knew that was abuse. The aide just smirked and kind of laughed. The resident told the CNA he/she was going to report what happened. He/She used the bathroom and then went to bed. When the resident got up the next day, he/she reported the incident to the nurse assigned to him/her. The resident didn't hear anything back from the nurse about what he/she reported. The resident went to the nurse in charge of that nurse. The resident told the Administrator and finally the doctor. He/She said the doctor told the Administrator. They finally gave him/her an x-ray, but he/she didn't know what the results were. He/She said there was a meeting with the ADON and Administrator. They all told him/her what CNA A did was unintentional. He/She knew when someone was doing something intentional to him/her. All CNA A had to do was apologize. It was intentional. The resident talked with staff a few weeks later and someone told him/her, You don't see CNA A around here, do you? He/She thought the CNA A was no longer working at the facility. The resident was shocked and flabbergasted when he/she saw CNA A working. No one does nothing and that makes the resident upset about it. It's like the facility doesn't care. They don't care but the resident cares. His/Her back was hurting today. His/Her pain level right then was about an 8. The pain medication just took the edge off. The pain was affecting his/her ability to put 100% into his/her therapy. He/She couldn't do his/her best because of the pain and couldn't make good progress. He/She wanted to start walking and get out of here.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/12/25 at 2:55 P.M., the ADON said the resident felt like CNA A was being rough. The resident was a bigger person. They told the resident the rough treatment was unintentional. She thought the resident may have fallen down hard, but knowing CNA A, they thought it was unintentional. CNA A used the sit to stand and said the resident didn't say anything. They educated CNA A and removed him/her from the resident's floor. CNA A received customer service and lift training. The resident wasn't a sit to stand at the time. He/She was moderate assist times one. He/She had come back from dialysis (a treatment to clean the blood when the kidneys are not able to) and was probably a little weak. She didn't know if the resident was assessed. It was decided the resident would use the sit to stand after dialysis because he/she was weaker when he/she came back to the facility. She wasn't sure if CNA A was suspended but he/she was taken off the schedule until they found out what happened with the alleged incident. No one talked to the CNA A about apologizing to the resident. The resident said he/she just wanted CNA A to apologize. CNA A was moved to a different floor and shift. They thought the resident would not see CNA A because he/she would be asleep.</p> <p>During an interview on 5/12/25 at 4:07 P.M., the Social Service Director (SSD) said the incident happened over the weekend. She wasn't there, so didn't get the initial information from the resident. When she spoke with the resident, he/she tried to fill her in on what happened. She couldn't remember off hand what the resident told her about the incident. She asked if the resident felt safe. He/She did.</p> <p>During a telephone interview on 5/12/25 at 7:39 P.M., CNA A said he/she guessed the resident had to go to the bathroom and was upset that he/she didn't get there right away. The resident rang his/her call light. He/She went to the resident's room and used the sit to stand to help him/her with the bathroom. He/She didn't push, stomp, or kick the resident. There were no words exchanged. As far as he/she knew, the resident was not upset. He/She was not given any corrective and/or disciplinary paperwork to sign. He/She gave his/her statement to the Executive Director/Administrator. He/She said the Executive Director called him/her to ask what happened. The Executive Director said the resident said CNA A was loud and irate. It was nighttime so he/she would never have been loud. Residents were asleep. He/She was taken off the schedule for seven days. He/She had in-service education on patient safety, transfers, and abuse. He/She worked at the facility, but was no longer assigned on the resident's unit.</p> <p>During an interview on 5/13/25 at 11:29 A.M., the Regional Nurse Coordinator (RNC) and Administrator were unaware of the resident wanting an apology from CNA A. They expected the Acting DON and nursing to follow up with the resident to address unresolved issues. Both the RNC and the Administrator expected the findings of the grievance process to be documented. They expected the resident to receive the outcome of the findings and said the resident should have been asked if he/she was alright with the things the facility did to resolve his/her issue with CNA A. They expected all facility staff to follow the grievance process policy.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on observation, interview and record review, the facility failed to complete a thorough investigation of alleged abuse for one resident per facility policy (Resident #1). Review of the facility soft investigation, provided during the onsite investigation, showed no written statement from the resident, actions taken, summary, and/or conclusion of the investigation or findings. The sample size was 4. The census was 115.</p> <p>Review of the Abuse Prevention policy, revised 8/2020, showed:</p> <ul style="list-style-type: none"> -Investigation: -The facility promptly and thoroughly investigates reports of resident abuse, mistreatment, neglect, injuries of an unknown source, or criminal acts; -If the Administrator receives a report of an incident or suspected incident of resident abuse, mistreatment, neglect, injuries of an unknown source or crime, the Administrator or designee, may appoint a member of the facility's management team (the investigator) to investigate the alleged incident; -If the investigation is delegated, the Administrator provides the investigator with any supporting documents related to the alleged incident; -The facility ensures protection of residents during abuse investigations; -The investigator may take some or all of the following steps: <ul style="list-style-type: none"> -Reviews all relevant documentation; -Reviews the resident's medical record to determine events preceding the alleged incident; -Interviews the person(s) making the alleged incident; -Interviews the resident's attending physician as need to determine the resident's current level of cognitive function and medical condition; -Interview facility staff members who have had contact with the resident during the period of the alleged incident; -Reviews all events leading up to the alleged incident; -Communicate with the Administrator daily regarding the progress of the investigation; and -Prepares an investigation report documenting findings of the investigation; -The investigator notifies the Ombudsman when an abuse investigation is being carried out; <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Facility staff who have been accused of abuse may be reassigned duties that do not involve resident care or suspended from duty until the Administrator has reviewed the investigation results;</p> <p>-The investigator records the investigation results on the Abuse Investigation Reporting Form;</p> <p>-The investigator provides a copy of the completed investigation report to the Administrator within 5 working days of the initial report of abuse, mistreatment, neglect, or unexplained injury;</p> <p>-The Administrator will provide a written report of the results of all abuse investigations and consequent actions to the appropriate agencies;</p> <p>-If the investigation substantiated the allegation, corrective action will be documented as part of the investigation and implemented to prevent recurrence;</p> <p>-If the investigation reveals that the initial report was unsubstantiated, the investigation ceases immediately;</p> <p>-The facility shall retain documentation relating to a facility staff member's involvement with the incident in the facility staff member's personnel record, according to regulation.</p> <p>Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/4/25, showed:</p> <p>-Cognitively intact;</p> <p>-Upper extremity impairment on one side;</p> <p>-Wheelchair;</p> <p>-Diagnoses included, anemia (lower than normal red blood cells or hemoglobin) and renal insufficiency (a condition where the kidneys don't function as well as they should).</p> <p>Review of the resident's progress notes, showed:</p> <p>-Late Entry-Social Service note, dated 3/5/25 at 5:23 A.M., the Social Worker, Executive Director and the acting Director of Nursing (DON) met with the resident to see what happened to him/her, and he/she was upset with the way he/she was being transferred. It was explained to him/her that the facility will start an investigation, and the facility wanted him/her to be safe and be comfortable;</p> <p>-Social Services note, dated 3/6/25 at 7:29 P.M., Social Worker spoke with the resident to see how he/she was doing and he/she stated he/she was fine. The resident told what the nurse did yesterday and that some x-rays were ordered. He/She was asked if he/she felt safe at the facility. He/She felt safe;</p> <p>-No other documentation related to the resident's allegation.</p> <p>Review of the resident's grievance/complaint report, dated 3/5/25, showed:</p> <p>(continued on next page)</p>		

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<p>F 0610</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 (be specific): The resident said that a certified nurse assistant (CNA A) slammed him/her into the restroom. CNA A wanted him/her to stand up. He/She told CNA A he/she needed the lift. CNA A slammed his/her leg against the resident's foot to get him/her off the toilet;</p> <p>-Signed 3/5/25 by Social Service Director;</p> <p>-For office use only:</p> <p>-Date: blank;</p> <p>-Received by: blank;</p> <p>-Title: blank.</p> <p>Review of the facility's investigation, showed:</p> <p>-3/5/25 CNA A's corrective action memo;</p> <p>-Employee written statement alleging incident date 3/1/25;</p> <p>-In-Service training dated 3/5, 3/6, 3/7, and 3/12/25;</p> <p>-Resident safety questionnaires;</p> <p>-No written resident statement of alleged incident;</p> <p>-No summary of action steps taken and/or recommendations;</p> <p>-No investigation report of the findings and/or conclusion of the investigation;</p> <p>-No documentation of notification of Ombudsman related to the soft investigation of allegation;</p> <p>-No Abuse Investigation Reporting Form;</p> <p>-No notification of investigation results to appropriate agencies;</p> <p>-No date(s) of the suspension and no documentation of in-service education related to the allegation.</p> <p>Review of the facility's re-education in-service, showed:</p> <p>-3/5/25, Customer Service training;</p> <p>-No documented training provided to CNA A;</p> <p>-3/6/25, Customer Service training;</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-No documented training provided to CNA A;</p> <p>-3/7/25, Customer Service training;</p> <p>-No documented training provided to CNA A;</p> <p>-3/12/25, Transfer training;</p> <p>-No documented training provided to CNA A.</p> <p>During an interview on 5/13/25 at 10:53 A.M., the Human Resource Manager said the Administrator and nursing were responsible for the investigation. She did not assist or participate in the investigation process.</p> <p>During an interview on 5/13/25 at 11:29 A.M., the Executive Director said this issue came up in March when the resident filed a grievance. He and the Acting Director of Nursing (Acting DON) spoke with the resident about what happened with CNA A. The allegation was discussed with the team. The team decided the allegation was a customer service issue when care was provided to the resident. The team didn't think it was abuse. The allegation wasn't investigated as abuse because the team decided it was a customer service issue with providing care. They in-serviced staff but can't explain why CNA A's signature wasn't on any of the in-service sheets. He/She was the reason the in-service training was being provided. The Executive Director and the Regional Nurse Consultant (RNC) both expected all allegations of known or suspected abuse to be investigated completely. They expected staff to have documented the details of the allegation in the resident's record. They expected the facility's abuse policy to be followed.</p>