

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 11/18/2025
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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to ensure medication was ordered timely and administered as ordered for one resident (Resident #1) who suffered from chronic pain. This caused the resident to experience severe pain and call emergency medical services to transport him/her to the hospital to receive his/her medication. The sample size was nine. The census was 118. Review of the facility's Pain Management policy, revised 6/20, showed: -Purpose: To ensure accurate assessment and management of the resident's pain; -Policy: A licensed nurse will assess residents for pain on admission and routinely as indicated by the resident's health and functional status. Facility staff is responsible for helping the resident attain or maintain their highest level of well-being while working to prevent or manage the resident's pain; -Procedure: --Pain assessment: --A licensed nurse will assess each resident for pain upon admission; --The licensed nurse will develop a care plan for pain management, including non-pharmacological interventions; --Pain management: --The licensed nurse will administer pain medication as ordered and document medication administered on the Medication Administration Record (MAR); --The licensed nurse will assess the resident for pain and document results on the MAR each shift using the 1-10 pain scale; --Nursing staff will implement timely interventions to reduce the increase in severity of pain. Review of Resident #1's medical record, showed: -Diagnoses included discitis of the unspecified thoracic region (a serious condition characterized by inflammation of the intervertebral discs, which are the soft, cushion-like structures located between the vertebrae of the spine), other chronic pain, post-polio syndrome (a condition that causes gradual muscle weakness and muscle atrophy (loss) that can affect people who have had polio.), unspecified abdominal pain, chest pain, unspecified, low back pain, unspecified and muscle weakness. Review of the resident's electronic Physician's Order Sheet (ePOS), showed an order dated 2/26/25, for oxycodone HCL (an opioid used to treat pain) 20 milligrams (mg), give one tablet by mouth four times a day. Review of the resident's pain clinic after visit summary, dated 5/20/25, showed: -Goals discussed: Chronic care plan; -Return in one month for pain management; -Analgesics: No changes. Cannot take over the counter supplements while in the facility. Review of the resident's pain clinic after visit summary, dated 6/20/25, showed: -Goals discussed: Chronic pain care plan; -Return in about three months. Review of the resident's July 2025 electronic Medication Administration Record (eMAR), showed: -An order with a start date of 2/26/25 to obtain pain level via numeric pain scale every shift (pain is rated on a scale of 1-10, with 10 being the highest); -An order for oxycodone HCL 20 mg, give one tablet by mouth, four times a day; -On 7/11/25, a 0 documented for pain level at midnight. Medication documented as administered at 12:00 A.M. Review of the resident's progress notes, showed on 7/11/25 at 12:57 A.M., a medication administration note for oxycodone HCL oral tablet, 20 mg. No medication to give. At 7:50 A.M., Medication was just delivered. Review of the resident's July 2025 eMAR, showed: -On 7/19/25, a 0 documented for pain level at 12:00 A.M. Nothing documented for pain level at 6:00 A.M. 0 documented for pain level at 12:00 P.M. A 7 documented at 12:00 A.M. for administration. Nothing documented at 6:00 A.M. for administration. A 9 documented at 6:00 P.M. for administration; -Chart code: 7 = Not administered/See progress note; -Chart code: 9 = Other/See progress notes. Review of the resident's progress notes, showed on 7/19/25 at 6:34 A.M., a medication administration note for oxycodone HCL oral tablet, 20 mg. Medication will arrive on next schedule run and made physician aware and no new order obtained. Review of the resident's July 2025 eMAR showed on 7/20/25, a 0 documented for pain level at 12:00 A.M., 6:00 A.M., 12:00 P.M. and 6:00 P.M. Medication documented as administered at 12:00 P.M. A 9 documented at 6:00 P.M. for administration. Review of the resident's progress notes, showed on 7/20/25 at 10:30 A.M., a medication administration note for oxycodone HCL oral tablet, 20 mg. Drug unavailable. At 1:57 P.M., Unavailable. Called physician. He stated could give whatever dosage of oxycodone staff had in stat kit which would equal ordered dosage. There was none in the stat kit. Review of the resident's July 2025 eMAR showed on 7/27/25, an X documented for pain level at 6:00 P.M. A 9 documented at 6:00 P.M. for administration. Review of the resident's progress notes, showed on 7/27/25 at 8:48 P.M., a medication administration note for oxycodone HCL oral tablet, 20 mg. On order. Pharmacy stated it will be here on the night run. Review of the resident's July 2025 eMAR showed on 7/28/25: -An X documented for pain level at 12:00 P.M. A 9 documented for pain level at 6:00 A.M.; -A 9 documented at 12:00 A.M. and 6:00 A.M. for administration. Review of the resident's progress notes, showed on 7/28/25 at 5:11 A.M., ordered from pharmacy. At 5:50 A.M., to be delivered on pharmacy run. Review of the resident's August 2025 eMAR showed: -An order for oxycodone</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</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>(continued on next page)</p>

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their Behavior Management and Resident Drug and Alcohol Abuse policies by failing to provide local services and resources for two sampled residents (Resident #1 and Resident #2) who were admitted with a history of substance abuse and continued to use and abuse illegal substances in the community. The residents left the facility on leave of absences (LOAs), sometimes for days. Resident #1 overdosed several times in the facility with illegal substances. Staff used Narcan several times to revive the resident. Resident #2 overdosed once in the facility and once in the community and was hospitalized twice with a diagnosis of drug overdose and severe intoxication. Both residents were allowed to continue to go out on LOA and return to the facility intoxicated. Additionally, Resident #2 made threats to shoot up the facility and made inappropriate sexual comments and gestures towards female staff. The census was 108. Review of the facility's Behavior Management policy, revised [DATE], showed:-Purpose: 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 residents' quality of life. To ensure 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 services which create an environment to promote emotional and psychosocial well-being, meet each resident's needs and include individualized approaches to care;-Upon observing the adverse behavioral symptom, staff will do the following as indicated: -Ensure the safety of the resident as well as all other residents;-Document the incident on the 24-hour report;-The Charge Nurse will assign a staff member(s) to monitor/shadow the resident as needed;-Such monitoring is for the protection of the resident as well as all others, and is not meant to restrict their movement or mobility;-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:-Date and time of behavior;-Location of resident when the behavior occurred;-Description of the behavior (e.g., what the resident said or did and if the behavior intensified);-Non-verbal cues;-What seemed to cause the behavior; and -Any interventions used and their effect.-In assessing the resident for potential causal factors, licensed nursing staff will consider the following factors and document their findings in the medical record:-Physical conditions (e.g., pain or discomfort, hunger or thirst, fatigue, toileting needs, incontinence);-Environmental conditions;-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);-Medical conditions that require treatment; -Mental health conditions, which may contribute to resident's behavior;-It is also important for the facility to use an interdisciplinary team (IDT) approach which includes the resident, their family, or resident representative. Review of the facility's Resident Drug and alcohol abuse policy, revised [DATE], showed:-Purpose: To provide a safe and drug-free environment for residents while at the facility;-The facility will admit a resident who has a history of drug and alcohol abuse if their primary diagnosis is suitable for skilled care;-The facility has a zero-tolerance policy for the use or possession of illegal drugs (including marijuana (a psychoactive drug that contains a chemical compound called tetrahydrocannabinol (THC), which is responsible for the intoxicating effects of marijuana.) or any type of drug paraphernalia in the facility or on the grounds of the facility;-All illegal drugs and/or drug paraphernalia will be confiscated from the resident and/or their room;-For the purpose of this policy alcohol is not considered to be an illegal drug;-The only drugs permissible at the facility and/or on facility grounds are those for which there is an attending physician order;-The facility has a zero-tolerance policy for the abuse of alcohol in the facility or on the grounds of the facility;-Any resident found in violation of this policy will be discharged to a more appropriate setting for care;-Social Services may provide residents with this policy in the following circumstances: -In the facility specific information provided to residents upon admission; -If the resident has a history of substance abuse:-a. alcohol;-b. narcotics; or-c. other substances; -If the resident is at risk for post-acute withdrawal symptoms; -If the resident is at risk for behavior disturbance;-If the resident has a substance abuse care plan;-If the resident has brought illegal drugs or alcohol into the facility; -If IDT feels it is appropriate to provide the resident with the policy;-After the Social Worker provides the resident with the policy, the resident</p>		