STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265607	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowcreek Wellness & Rehabilitation	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record review, the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good personal hygiene for one resident (Resident #8). The resident called staff to the room and requested to be cleaned of incontinence and was told to wait for the next shift. The sample was 7. The census was 107.Review of the facility's Perineal Care policy, dated 6/2020, showed:-Purpose: To maintain cleanliness of the genital area, to reduce odor, and to prevent infection or skin breakdown;-Perineal care is provided as part of a resident's hygienic program, a minimum of once daily and per resident needs. Review of Resident #8's medical record, showed:-Diagnoses included muscle weakness and need for assistance with personal care;-A Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 11/13/25, showed the resident cognitively intact. Dependent on staff for personal hygiene. Frequently incontinent of urine. Always incontinent of bowel;-A care plan, in use at the time of the investigation:--Focus: Activity of daily living (ADL) self-care performance deficit/requires assistancewith all ADLs;---Goal: Will be properly dressed and groomed daily;--Staff to assist as needed with care. Observation on 2/5/26 at 6:34 A.M., showed the resident in his/her room and appeared to be asleep. An odor of bowel movement in the room. Observation on 2/5/26 at 6:51 A.M, showed the resident's call light lit up above the resident's door and beeped at the nurse's station. At 6:52 A.M., a staff member walked down the hall and entered the resident's room. The resident spoke to the staff member and staff member said they are waiting for day staff to come in. The staff member had turned off the call light and exited the room. At 6:53 A.M., the resident said he/she told the staff person he/she needed to be cleaned up and was told he/she had to wait. This happens all the time. Everyone says they are not his/her aide and will not help him/her. His/Her bottom burns when he/she is not cleaned up. Review of the staffing sheet for the resident's hall, showed on the 11:00 P.M. to 7:00 A.M. shift, Certified Nursing Assistant (CNA) A assigned to the resident. Observation on 2/5/26 at 7:06 A.M., showed the resident's call light turned back on. At 7:07 A.M., a staff member walked down the hall and entered the room. The indicator light above the door turned off. The staff member said I do not know who the aide will be today. The staff member exited the room. A second staff member entered the room. He/She introduced him/herself as the nurse and asked if the resident needed anything from him/her. The resident's response could not be heard. The staff person exited the rom. The first staff member talked to the nurse as they walked down the hall, away from the resident's room, and said he/she did not have the resident on his/her assignment, he/she was just answering the light. The nurse said okay. Both staff left the hall. At 7:18 A.M., CNA B arrived to the room and said the nurse is about to do wound care. At 7:20 A.M., Licensed Practical Nurse (LPN) D arrived at the room. CNA C arrived to the room. At 7:23 A.M., the three staff assisted the resident on his/her back, uncovered the resident and unsecured the resident's brief. A large amount of soft bowel movement was on the resident's buttocks and pushed up into the resident's wound dressing. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The CNAs provided personal hygiene and LPN D completed wound care. The resident said his/her bottom is getting sore. During an interview on 2/5/26 at 4:03 P.M., the Nurse Consultant/Interim Director of Nursing said residents should be provided care as soon as they request it and staff get the assistance they need. It is not acceptable to ask a resident to wait for the next shift to come in. 2719750

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice when staff failed to change a Peripherally Inserted Central Catheter line (PICC, central line placed in the upper arm into a large vein near the heart for long term intravenous (IV) medications) dressing as ordered and ensure the dressing was secured to prevent the risk of infection to the insertion site, for one resident (Resident #10). The sample was 7. The census was 107. Review of Resident #10's medical record, showed:-Diagnoses included osteomyelitis (bone infection) of the vertebra (spine);-An order dated 1/15/26, for central line dressing change every 7 days and as needed for PICC line left upper extremity;-A treatment administration record, dated January 2026, showed the PICC Line dressing change not documented as completed;-A treatment administration record, dated February 2026, showed the PICC line dressing change not documented as completed. The next scheduled treatment, that prompts staff to change the PICC line dressing, not scheduled to trigger on the treatment administration record until 2/11/26. Observation and interview on 2/5/26 at 3:00 P.M., showed the resident in his/her room in bed. His/her parent was on the phone. The resident said he was admitted on [DATE]th and was admitted with his/her PICC line for antibiotics. He/She has an infection in his spine. The resident's parent said the infection control doctor said the dressing to the PICC line needed to be changed at least weekly and staff do not change it. The resident said the dressing on his/her PICC line site was changed on 1/29/26 and that is the first time staff changed it at the facility. They changed it because it was coming off, and now it is coming off again. Observation showed antibiotics infused into the left arm PICC line. The outer aspect of the PICC line dressing hung off loosely. The resident lifted the edge up and showed that it could be pulled up almost to the insertion site. During an interview on 2/5/26 at 4:03 P.M., the Nurse Consultant/Interim Director of Nursing said if a dressing is changed as needed, it does not change the due date for the next treatment. If the treatment is loose or is falling off, staff need to clean the site and replace the dressing. If the PICC line looks like there are integrity issues, staff need to contact the physician. 2736346

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to ensure a resident with pressure ulcers (injury to the skin as a result of pressure or friction) receives treatments as ordered when staff failed to apply wound care as ordered by the physician for one resident (Resident #8). The sample was 7. The census was 107.Review of the facility's Wound Management policy, dated 6/2020, showed:-Purpose: To provide a system for the treatment and management of residents with wounds, including pressure and non-pressure injury;-Policy: A resident who has a wound will receive necessary treatment and services to promote healing, prevent infection, and prevent new pressure injuries from developing. Review of the resident's medical record, showed:-Diagnoses included muscle weakness and need for assistance with personal care;-An order dated 1/8/26, to cleanse coccyx (tailbone area) with normal saline/Vashe (wound cleanser), pat dry, apply Santyl (wound debridement ointment), apply calcium alginate ag (absorbent dressing) and cover with dry dressing daily and as needed. Review of the facility's wound report, dated 1/26/26 through 2/2/26, showed the resident with a coccyx pressure ulcer stage 3 (full thickness tissue loss, subcutaneous fat may be visible but the bone, tendon or muscle is not exposed). Observation on 2/5/26 at 7:23 A.M., showed Licensed Practical Nurse (LPN) D completed wound care for the resident after the treatment became soiled. LPN D assisted the resident to his/her left side and cleansed the wound with wound cleanser. He/She then packed the wound with calcium alginate and covered with boarder gauze. No Santyl applied to the wound. During an interview on 2/5/26 at 4:03 P.M., the Nurse Consultant/Interim Director of Nursing said if a dressing is soiled and required to be changed at a non-routine time, staff should still apply the treatment as ordered. 2719750