| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265607 | A. Building<br>B. Wing | 03/18/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Willowcreek Wellness & Rehabilitation | 250 New Florissant Road South<br>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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to accurately document physician ordered treatments on the Treatment Administration Record (TAR) for three residents (Residents #77, #112 and #92). The sample was five. The census was 112.Review of the facility's Documentation - Nursing Policy, dated 6/20, showed:-Purpose: To provide documentation of resident status and care given by nursing staff;-Policy:--Nursing documentation will be concise, clear, accurate and evidence based. Narrative charting, as outlined in specific policies and procedure, will be used for initial treatments or procedure. Documentation for subsequent and/or routine care and procedures may be completed by exception. Checklists, flow charts and other documentation tools will be used as appropriate.--Nursing staff will not falsify or improperly correct nursing documentation.-Procedure:-Alert Charting describes what is going on;--Describe the resident's condition, include what you see, hear, smell, feel, etc. 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;-A resident who has a wound will receive necessary treatment and service to promote healing, prevent infection and prevent new pressure injuries from developing;-III. Documentation:--Licensed Practical Nurse (LPN), Registered Nurse (RN) will document effectiveness of the current treatment in the resident's medical record on a weekly basis. 1. Review of Resident #77's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/4/26 showed:-admission date: 8/22/25;-Diagnoses included: Anemia (lack of healthy red blood cells), diabetes, lung disease. Review of the resident's physician's order summary report, showed:-Order dated 2/23/26, right posterior buttocks, cleanse with normal saline, pat dry and apply Calcium Alginate (Ca+ Ag, a highly absorbent, biodegradable, and biocompatible wound dressing), cover with silicone foam dressing daily and as needed (PRN);-Order dated 2/27/26, right foot, paint with Betadine (powerful, amber-colored antiseptic solution used to kill bacteria), cover with dry dressing daily and as needed. Review of the resident's Treatment Administration Record dated 3/2026, showed:-Right posterior buttocks, cleanse with normal saline, pat dry and apply Ca+ Ag, cover with silicone foam dressing daily and PRN;--On 3/17/26, documentation blank;- Right foot paint with Betadine, cover with dry dressing daily and as needed;--On 3/17/26, documentation blank. Observation on 3/18/26 at 9:01 A.M., showed, the resident's bandage to the right leg and foot dressing was dated for 3/16/26. Observation on 3/18/26 at 9:26 A.M., showed the resident had a dressing on his/her coccyx dated 3/17/26. During an interview on 3/18/26 at 9:26 A.M., Wound Nurse 1 said, he/she works Monday through Friday as the wound nurse. He/She expected the nurses to review the resident's Treatment Administration Record and change the dressing if it's soiled or outdated. During an interview on 3/18/26 at 8:59 A.M., Wound Nurse 2 said, he/she worked the floor last night (3/17/26). At 9:26 A.M., Wound Nurse 2 said he/she changed the dressing on the right foot on 3/16/26. 2. Review of Resident #112's quarterly MDS, dated [DATE], showed:-admission date: 1/30/24;-Diagnoses included: Anemia, hyponatremia (low sodium), hip fracture, malnutrition, lung disease. Review of the resident's order summary report, showed:-A<br>(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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | physician order, dated 4/8/25, sacrum (tailbone) cleanse with normal saline (NS sterile water) Vashe (wound cleanser) pat dry pack with calcium alginate, change daily or as needed. Observation on 3/18/26 at 11:52 A.M., showed the resident's bandage on the sacrum was dated for 3/17/26. During an interview on 3/18/26 at 11:52 A.M., Wound Nurse 2 said the current bandage date was 3/17/26. Review of the resident's TAR, dated 3/2026, showed:-Sacrum wound, blank entries, for four of 11 opportunities;- On 3/17/26 sacrum wound showed a blank entry, no documentation regarding the wound dressing change on 3/17/26. 3. Review of Resident #92's admission MDS, dated [DATE], showed:-admission date: 2/23/26;-Diagnoses included: Anemia, renal disease, stroke, malnutrition, lung disease. Review of Resident #92's TAR, dated 3/2026, showed:-A physician order, dated 3/12/26, left inner thigh and left stump, cleanse with NS or wound cleaner, Ca+ Ag, cover with dry dressing daily and PRN;-One out of three opportunities left blank. 4. During an interview on 3/18/26 at 8:39 A.M., Wound Nurse 1 said there are no residents that are missing their treatments. The vibe was clock out after eight hours even if wounds aren't finished. 5. During an interview on 3/18/26 at 1:39 P.M., the Director of Nursing (DON) said she expected all treatments to be documented at the time they are completed. 6. During an interview on 3/18/26 at 1:39 P.M., the Regional Nurse said nurses have a computer on their carts specifically to chart in real time after a treatment is completed. 7. During an interview on 3/18/26 at 2:11 P.M., the Administrator said she expected the nursing department to chart on the treatments being completed. She would expect precise charting to be done. 28059852805846 |