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	05/27/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff immediately reported an allegation of abuse in accordance with the facility's policy, resulting in a delayed response and investigation, and the facility's failure to report the allegation to the Department of Health and Senior Services (DHSS) within the required two-hour timeframe for one resident (Resident #1). The sample was 4. The census was 110.The Administrator was notified on 05/27/26 of the past non-compliance, which occurred on 05/15/26. The facility in-serviced staff regarding Abuse and Neglect reporting protocols and staff demonstrated understanding. The deficiency was corrected on 05/20/26. Review of the facility's Abuse Prevention and Prohibition policy, revised 01/26, showed:-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;-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;-Prevention:--Supervisors shall immediately intervene, correct, and report identified situations where abuse, neglect or misappropriation of resident property is at risk for occurring;-Reporting/Response:--Facility staff are mandatory reporters:---Facility owners, operators, employees, managers, agents, and contractors are obligated to report known or suspected instances of abuse of elder or dependent adults;---Facility staff will report known or suspected instances of abuse to the Administrator, or his/her designee;--The facility will report allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property, or other incidents that qualify as a crime;---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, adult protective services, law enforcement, and the Ombudsman (if applicable per state regulation). Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 05/28/26, showed:-Moderate cognitive impairment;-No hallucinations or delusions;-No rejection of care behavior;-Impairment of both upper and lower extremities;-Dependent on assistance with activities of daily living (ADLs);-Diagnoses included central cord syndrome (CCS, an injury to the central part of the spinal cord in the neck), cognitive communication deficit, need for assistance with personal care, weakness, and muscle spasms. During an interview on 05/27/26 at 1:08 P.M., the resident said a Certified Nurse Aide (CNA) was changing him/her and the CNA stuck his/her finger into the resident's rectum. The resident said, Fuck, what are you doing? The CNA said he/she rubbed something off his/her buttocks. The resident told the CNA that he/she stuck his finger up the resident's buttocks and the CNA said, Oh, sorry my bad. The resident felt like he/she was sexually abused because nobody else had ever put their finger into his/her rectum. He/She told the nurse he/she did not want the CNA to come in and take care of (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	him/her anymore. He/She did not know the CNA's name. Review of the facility's investigation, dated 05/22/26, showed:-On 05/16/26, the resident reported an allegation of abuse to Housekeeper (HK) A;-On 05/16/26, HK A reported the allegation of abuse to the Housekeeping Supervisor (HKS);-On 05/18/26, HK A was asked to identify the resident;-When questioned regarding the delay in further reporting, HK A stated he/she was unable to recall the resident's name or room number at that time;-Once the resident was identified, the Regional Director of Operations (RDO) and the Director of Social Services conducted an interview to obtain the resident's statement. During an interview on 05/27/26 at 10:17 A.M., HK A said on 05/15/26, between 10:00 A.M. and 11:00 A.M., the resident reported a couple weeks ago, one of the CNAs touched him/her inappropriately by putting their finger into the resident's rectum. The resident identified the CNA to HK A as CNA B when he/she walked by his/her room. HK A attempted to report it before he/she left for the day at 2:00 P.M., but nobody was in the office. He/She called the HKS that night or the night after and reported the allegation. HKS said she would report it to the appropriate person. During an interview on 05/27/26 at 12:19 P.M., HKS said HK A called her on the evening of 05/16/26 and reported the resident alleged he/she was abused by CNA B when the CNA put his/her finger into the resident's rectum. On 05/18/26, HKS asked HK A to show her who the resident was, and she then reported the allegation to the RDO. Nobody was at the facility over the weekend and she did not know that she should have come up to the facility on [DATE] when the allegation was initially reported to her. She has since received training on the facility's abuse reporting policy. During an interview on 05/27/26 at 3:30 P.M., RDO said the HKS reported the allegation of abuse on 05/18/26. RDO asked the HKS when the allegation happened and when the resident reported it to HK A. HKS said the resident reported the allegation to HK A on 05/15/26, and it was reported to HKS on 5/16/26. HKS said HK A did not know the resident's name or room number and was off work for two days, so HKS waited until 05/18/26 when HK A returned to work to identify the resident. During an interview on 05/27/26 at 3:42 P.M., the Administrator said he expected any allegation of abuse to be reported immediately, up through the chain of command and to the Administrator. He expected the allegation to be reported to DHSS within the required two-hour timeframe. He expected the facility staff to ensure the resident's safety, to suspend the staff named in the allegation, and to complete an investigation related to the allegation. He expected HK A to have reported the allegation immediately to the Administrator or his/her supervisor. The Administrator expected the HKS to report the allegation immediately, even if she did not know the resident's name or room number. The Administrator expected staff to be knowledgeable of and to follow facility policies and procedures. 3017546