

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375436	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER Willow Creek Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 West Noble Guthrie, OK 73044	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to ensure food was served at safe temperatures for 50 of 51 residents who received meals from the dietary department. Specifically, the facility did not maintain hot food holding temperatures at 135 degrees Fahrenheit (F) or above during meal service. Findings included: A facility policy titled, Food Holding and Service, revised 06/01/2019, revealed Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be held and served according to the state and US [United States] Food Codes and HACCP [Hazard Analysis and Critical Control Points] guidelines. Procedure: 1. Serve all hot foods at a temperature of 135 F or greater and all cold food at 41 F or less. Adjust the temperature to account for the time the food will be held prior to service on the steam table and on the tray carts. During a kitchen observation on 07/13/2026 at 11:23 AM, two plates of cheeseburgers and a plate of corn dogs were observed sitting out next to the steam table in the kitchen. Using a facility issued digital food thermometer, [NAME] #14 took the temperatures of the food items. The temperature of the cheeseburger was 120 F, and the temperature of the corn dogs was 121 F. A bowl of chicken noodle soup was observed to be poured from the can into a bowl to be served. The soup was microwaved to 129 F. During an observation on 07/13/2026 at 12:59 PM, Resident #49 received a cheeseburger at a temperature of 91 F. During a meal observation on 07/15/2026 at 11:23 AM, a hamburger plate and a plate of chicken tenders were observed sitting out next to the steam table in the kitchen. The temperature of the hamburger was 104.5 F, and the temperature of the chicken tenders was 126.3 F. During an interview on 07/15/2026 at 11:43 AM, [NAME] #14 stated they did not reheat the food. When asked why they did not reheat the food, [NAME] #14 stated, residents do not like their food steaming hot. During a meal observation on 07/15/2026 at 11:53 AM, tilapia (fish) was observed on the steam table in the upstairs dining area. The temperature of the tilapia was 109.7 F. Further observation of the meal service revealed Resident #18 was served the tilapia at 12:22 PM. The temperature of the tilapia was 103 F at the time it was served. During an interview on 07/15/2026 at 1:15 PM, the Certified Dietary Manager (CDM) stated the expectation was for the staff to take the temperature of the food once it was finished cooking. The CDM stated that the food temperature was to be taken when the food item finished cooking and before it went up to the unit. The CDM stated the food temperature was to be higher than the holding temperatures, so when it went upstairs, it was held at a higher temperature than the holding temperature of 135 F. The CDM stated the food temperature was to be taken once the meal was set up on the steam table in the upstairs dining area. The CDM stated if the food was not at or above the hot holding temperature of 135 F, the staff were expected to heat the meal to 165 F. During an interview on 07/17/2026 at 1:53 PM, the Administrator stated her expectation was for staff to hold meals above 135 F. The Administrator stated if the temperature of the food was not at the hot holding temperature, she (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	expected staff to reheat the meal or make the meal again. During an interview on 07/17/2026 at 2:23 PM, the Quality Assurance (QA) Corporate Nurse stated that if the meal was not held at the proper hot holding temperature, the food should be reheated to the proper temperatures or remade, especially fish. She stated the staff should know what temperatures the food should be held at and to cook the food accordingly. She stated that not serving the food at the proper temperature had the potential to cause food borne illness. During an interview on 07/17/2026 at 2:26 PM, the Director of Nursing (DON) stated the expectation was for the staff to know the food holding temperatures and maintain food at the appropriate temperatures.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and facility policy review, the facility failed to develop, implement, and maintain a process for monitoring the facility's water system for potential waterborne pathogens. Additionally, nursing assistant students (Students) and dietary staff failed to implement hand hygiene when plating food, serving plates, and assisting residents with meals for 3 of 3 meal service observations. Findings included: 1. A facility policy titled, Infection Prevention and Control Program, revised 07/2024, specified, Water Management: Control measures and testing protocols are in place to address potential hazards associated with the facility's water system. The Maintenance Director oversees the facility's water system. An undated facility policy titled, Legionella Surveillance and Detection, specified, Our facility is committed to the prevention, detection and control of water-borne contaminants. On 07/14/2026 at 11:00 AM, the Maintenance Director stated the facility had last performed annual testing of the facility's water for Legionella on 11/05/2025. The Maintenance Director stated the facility did not have a flow diagram of the facility's water system, had not assessed potential locations in the facility's two-story building water system where water may be held or accumulated, and had not implemented control measures to mitigate any potential waterborne pathogens. On 07/16/2026 at 11:00 AM, the Quality Assurance Corporate Nurse (QACN), who was the Infection Preventionist (IP), stated she was unaware of any control measures to mitigate any potential waterborne pathogens as part of the facility's Infection Control and Prevention Program (ICPP). The QACN stated the ICPP had been last reviewed on 01/13/2026. On 07/17/2026 at 11:25 AM, the Administrator stated the Maintenance Director was hired in April 2026 and did not have any prior long-term care facility experience. The Administrator confirmed the facility did not have a flow diagram or control measures in place to mitigate potential waterborne illnesses. The Administrator stated her expectation would be to develop and institute a monitoring program to meet the regulation. 2. A facility policy titled, Infection Prevention and Control Program, revised 07/2024, specified, Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. An undated facility policy titled, Alcohol-Based Hand Rubs, specified, All personnel are provided with hand hygiene training upon hire and annually thereafter. Hand hygiene competency of staff is measured, including thorough return demonstration to verify technique. All personnel are required to adhere to hand hygiene policies and practices. Staff adherence to hand hygiene is incorporated into infection prevention and control process surveillance and monitored by Infection Preventionist. Alcohol based hand rubs are the preferred method of performing hand hygiene in most situations. Hand hygiene is indicated:- before touching a resident- before preparing or handling food, medications, or parenteral situations- before clean or aseptic procedures- before moving from work on a soiled body site to a clean body site on the same resident- after exposure to blood, body fluids, excretions or contaminated surfaces- after touching a resident- after touching resident's environment or belongings- after glove removal- whenever hands are visibly soiled. Observations on 07/13/2026 at 12:10 PM during lunch service revealed Student #1 and Student #2 were sitting at a table in the dining room with Resident #35 while waiting for the table to be served from the kitchenette adjacent to the dining room. Student #1 was observed touching the Resident #35's bib cover and clothing, and Student #1 was observed touching their scrub clothing prior to service, placing their hands in their lap, and touching their hair. Student #2 was observed touching their scrub clothing prior to service and placing their hands in their lap. Both Students then assisted the resident with a beverage by lifting the cup with the beverage from the table to the resident's mouth so the resident could drink out of the straw. The observation revealed the Student Preceptor intervened and gave the students (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	alcohol-based hand sanitizer (ABHS) to use prior to continuing to assist Resident #35. On 07/13/2026 at 12:12 PM, Dining Aide (DA) #3 was observed serving plates of food from the kitchenette without using repeat hand hygiene between residents. DA #3's hands were touching the edges of the plate including the food area of the plate with her ungloved hand when receiving the plates from the steam table service area then taking them to the resident. The observation revealed DA #3 was wearing a surgical mask during dining service, touched her mask with her hand, and did not repeat hand hygiene prior to receiving another plate of food from the steam table area and delivering the plate to a resident. The observation revealed DA #3 went into the kitchenette office area, touched the doorknob and items inside the office area, and returned to serving residents without repeating hand hygiene prior to taking plated food from the steam table area and delivering the food to the residents at their tables in the dining room. On 07/13/2026 at 12:15 PM, the Student Preceptor stated it was the students' first day in the facility, and the Student Preceptor expected the students to use proper hand hygiene. The Student Preceptor confirmed the students had potentially contaminated their hands by touching the resident, their clothing, and their hair prior to assisting the resident with a beverage. The Student Preceptor stated if students touched anything they should repeat hand hygiene prior to assisting residents with dining. On 07/15/2026 at 12:48 PM, the Certified Dietary Manager (CDM) stated dietary staff normally served the residents in the dining room from the kitchenette. The CDM stated staff did not normally do hand hygiene if holding the plate from the bottom only between serving plates of food to residents. The CDM stated staff were not supposed to touch the plate area where food or eating might occur, and if they did they should perform repeat hand hygiene between residents being served food. The CDM agreed DA #3 had her hands on the side of the plate where food or eating might occur and should have used repeat hand hygiene between residents. On 07/17/2026 at 9:17 AM, the Director of Nursing (DON) stated she expected the nursing assistant students to follow the facility's policy for hand hygiene. On 07/17/2026 at 9:20 AM, the Administrator stated her expectation for staff and students would be to perform hand hygiene before and after interactions with residents, before and after each job function with residents, and before and after each glove use. On 07/17/2026 at 1:20 PM, DA #3 stated hand hygiene should be done during dining service between resident plates since they were touching plates and if they left the area and returned. DA #3 confirmed she did not repeat hand hygiene after she left the area and returned, after she touched her face mask, and after she touched the edges of plates during dining service to residents. 3. A facility policy titled, Infection Prevention and Control Program, revised 07/2024, specified, This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. An undated facility policy titled Alcohol-Based Hand Rubs specified, Hand hygiene is indicated:- before touching a resident- before preparing or handling food, medications, or parenteral situations. During an observation of meal service on 07/13/2026 at 12:23 PM, [NAME] #14 repeatedly touched residents' diet roster papers and repeatedly touched and adjusted their mask while preparing the lunch plates for residents. [NAME] #14 was not observed to wash their hands or perform hand hygiene after touching their mask or the papers. During an observation of meal service on 07/13/2026 at 12:46 PM, [NAME] #14 touched the face of a resident's plate, the area of the plate the residents ate from, and then gave the plate of food to the certified nursing assistant (CNA) to give to a resident. The observation revealed [NAME] #14 continued to touch the face of the plates while serving. The observation revealed no hand hygiene was performed by [NAME] #14 between repeatedly touching the diet roster papers, repeatedly adjusting their face mask, and touching the faces of the resident's plates prior to (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	plating the residents' meals. During an interview on 07/17/2026 at 1:24 PM, the Certified Dietary Manager (CDM) stated the staff were supposed to use proper hand washing and sanitizer when touching different surfaces and serving the resident's meals. The CDM stated staff were not supposed to touch the face of the resident's plate. The CDM stated if the staff did touch the face of the plate, they were expected to change the plate. During an interview on 07/17/2026 at 1:53 PM, the Administrator stated the expectation was for staff to practice proper hand hygiene at all times, especially when touching different surfaces. During an interview on 07/17/2026 at 2:23 PM, the Quality Assurance Corporate Nurse (QACN), who was the Infection Preventionist (IP), stated the expectation of the dietary staff was to use hand hygiene just as all staff were required to do. During an interview on 07/17/2026 at 2:26 PM, the Director of Nursing (DON) stated the staff were expected to maintain hand hygiene at all times in the kitchen and while serving food on the unit. The DON stated the dietary staff had access to hand washing and sanitizing resources.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, record review, and facility policy review, the facility failed to treat residents with dignity and respect for 2 (Resident #15 and Resident #26) of 2 sampled residents reviewed for dignity. Specifically, Certified Nursing Assistant (CNA) #4 asked Resident #15 if the resident was a gang member, and, while the resident tried to explain, the staff member was not responsive. Additionally, Resident #26 did not receive attentive feeding assistance from CNA #4. Findings included: The facility's undated policy titled, Resident's Rights and Responsibilities, indicated, Every resident shall have the right to receive courteous and respectful care and treatment. 1. A Resident Face Sheet revealed the facility admitted Resident #15 on 04/03/2026. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of generalized anxiety disorder and other recurrent depressive disorders. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/26/2026, revealed Resident #15 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident received medication for anxiety disorder and depression. Resident #15's Care Plan included a problem statement, edited 04/22/2026, that indicated the resident had shortness of breath at times. Interventions directed staff to provide a calm environment free of stimuli to reduce/prevent anxiety. Resident #15's Care Plan included a problem statement, created 04/22/2026, that indicated the resident had a hearing loss. Interventions directed staff to face the resident when speaking. During an observation on 07/16/2026 at 11:56 AM, Certified Nursing Assistant (CNA) #4 and Resident #15 were observed sitting at a table in the dining room. The observation revealed CNA #4 asked Resident #15 if they were a gang banger (member of a gang). The observation revealed Resident #15 attempted to answer CNA #4 and explain the history of their tattoos when CNA #4 crossed her arms, appeared to be frustrated, and said she needed a break from the resident. The observation revealed a few minutes later CNA #4 left the table. During an interview on 07/16/2026 at 1:45 PM, CNA #4 stated she did ask Resident #15 if they were a gang banger. CNA #4 stated it was just a conversation. During an interview on 07/16/2026 at 3:58 PM, Resident #15 stated that CNA #4 had asked them if they were part of a gang. Resident #15 stated it was not a nice thing to say to them, but they had been asked that all of their life because of their tattoos. Resident #15 stated they tried to answer and explain to CNA #4, but she would not answer them back, even though she was sitting at the same table. During an interview on 07/17/2026 at 11:32 AM, Licensed Practical Nurse (LPN) #5 stated he was not paying attention to CNA #4 and Resident #15's conversation but did notice Resident #15 try to talk to CNA #4 about the tattoos and CNA #4 did not respond to the resident and later got up and left the table. LPN #5 stated he did not hear what CNA #4 said to Resident #15, but if she had asked Resident #15 if they were part of a gang or gang banger that would not be appropriate. During an interview on 07/17/2026 at 12:54 PM, the Director of Nursing (DON) stated she expected the staff to have appropriate conversations with the residents. The DON stated the conversation that CNA #4 had with Resident #15 was inappropriate. The DON stated she expected the staff to interact with the residents but not to have a conversation that may embarrass a resident. The DON stated she expected staff to treat residents with respect and dignity. During an interview on 07/17/2026 at 1:21 PM, The Administrator stated she expected the staff to have appropriate conversation with the residents, and the dialogue should always be appropriate. The Administrator stated she had reviewed the camera, and, although there was no sound on the video, CNA #4's body language did not appear inviting. The Administrator stated she could see Resident #15's attempt to interact with CNA #4. 2. A (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident Face Sheet indicated the facility admitted Resident #26 on 04/05/2024. According to the Resident Face Sheet, the resident had a medical history that included a diagnosis of dementia. A significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/21/2026, revealed Resident #26 had severe impairment in cognitive skills for daily decision-making and had a short-term and long-term memory problem per a staff assessment of mental status (SAMS). The MDS indicated the resident was dependent on staff for eating. Resident #26's Care Plan included a problem statement, edited 03/27/2026, that indicated the resident needed assistance with Activities of Daily Living (ADL). Interventions directed staff to provide setup assistance for eating (05/17/2024). Resident #26's Care Plan included a problem statement, edited 04/05/2024, that indicated the resident received a regular diet. Interventions directed staff to encourage the resident during meals as needed (04/05/2024). An observation on 07/13/2026 at 12:15 PM revealed Resident #26 was in the dining room, when CNA #4 sat down beside the resident and assisted the resident with their meal. The observation revealed within a few minutes CNA #4 started a conversation with a visitor and stopped assisting Resident #26 with their meal. The observation revealed Resident #26 began to feel for their plate and use their fingers to eat their food. The observation revealed CNA #4 did not interact with the resident or ask the resident if they needed or wanted assistance with their meal. The observation revealed CNA #4 picked up Resident #26's spoon, and, without speaking to the resident, put the spoon to the resident's mouth, and the resident appeared to be startled when the spoon touched their mouth. An observation on 07/13/2026 at 12:48 PM revealed CNA #4 left Resident #26's table and got herself a plate from the dietary staff. The observation revealed CNA #4 took her plate and sat back down beside Resident #26 and ate her food. The observation revealed CNA #4 did not offer to assist Resident #26 with their meal, but CNA #4 continued to eat her food and talk to the visitor until she finished her food, and then she left the table. A dining observation on 07/16/2026 at 12:38 AM revealed CNA #4 sat down beside Resident #26. The observation revealed Dietary Aide (DA) #3 gave Resident #26 their plate, the resident began to feel for their plate and drinks, and the resident started to eat their food. The observation revealed CNA #4 had conversation with other staff members but no conversation with Resident #26. The observation revealed CNA #4 picked up Resident #26's spoon, put food on the spoon, and attempted to put the spoon in the resident's mouth while the resident was still chewing food. The observation revealed CNA #4 poured sweet and sour sauce on the Resident #26's rice without asking the resident. The observation revealed on multiple occasions CNA #4 put the spoon up to Resident #26's mouth while the resident was still chewing food. CNA #4 was not observed to have any interactions with Resident #26 or to let the resident know she had another bite of food for the resident. CNA #4 was observed to cross her arms in frustration when Resident #26 was still chewing their food. CNA #4 was observed to put the cup up to Resident #26's mouth without notifying the resident of the drink, and the resident was startled when the cup touched their lips. The observation revealed on 07/16/2026 at 12:47 PM CNA #4 got up from the table and left the dining room, and Resident #26 was then observed to feel for their plate and finished their meal. During an interview on 07/16/2026 at 1:06 PM, CNA #10 stated that when they assisted the residents with their meals they were supposed to interact with the residents. CNA #10 stated if they did not communicate with Resident #26 the resident would be startled because the resident could not see the spoon coming towards their mouth until it touched their mouth. CNA #10 stated she should always allow the resident to chew and swallow their food and then offer the resident a drink before trying to give the resident more food. CNA #10 stated it was not okay to eat with a resident if the residents were still eating or needed assistance. CNA #10 stated staff should interact with the residents, and staff should ask the resident if they wanted seasonings, (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure the call light was maintained within reach for 1 (Resident #1) of 1 resident reviewed for tube feeding. Findings included: A facility policy titled, Answering the Call Light, revealed, The purpose of this procedure is to respond to the resident's requests and needs. The policy also indicated, General Guidelines 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. A Resident Face Sheet revealed the facility readmitted Resident #1 on 03/17/2026. The Resident Face Sheet indicated the resident had a medical history that included diagnoses of cerebral infarction, unspecified dementia, [NAME]-[NAME] gastro-esophageal laceration-hemorrhage syndrome (a condition involving mucosal tears at the gastroesophageal junction), and gastrostomy status. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/22/2026, indicated Resident #1 had severe impairment in cognitive skills for daily decision making and had a short-term and a long-term memory problem per a staff assessment of mental status (SAMS). The MDS indicated Resident #1 was dependent on staff for all activities of daily living (ADLs). Resident #1's Care Plan revealed a problem area, edited 03/11/2025, that indicated the resident was at risk for serious injury related to falls due to impaired balance, urinary incontinence, and degeneration of the brain. Interventions directed staff to keep the call light, personal items, and frequently used items within easy reach (08/22/2017). An observation on 07/13/2026 at 11:33 AM revealed Resident #1 lying on their back in bed with a wedge pillow under their right arm. The observation revealed Resident #1's pressure pad call light device was clipped at the top, left side of the bed, out of reach of the resident. An observation on 07/14/2026 at 10:22 AM revealed Resident #1 lying on their back in bed. The observation revealed a pressure pad call light device clipped to the privacy curtain, approximately three feet from the bed, and out of reach of the resident. An observation on 07/15/2026 at 5:57 AM revealed Resident #1 lying on their back in bed with the pressure pad call light device attached to the right top corner of the sheet, hanging over the right top corner of the bed out of reach of the resident. An observation and concurrent interview on 07/15/2026 at 1:09 PM revealed Resident #1 lying on their back in bed with the call light pad placed at the right top of the bed beside the resident's head. Licensed Practical Nurse (LPN) #8 stated the call light pad was at the top of the bed beside Resident #1's head, and the resident could not reach it. LPN #8 stated Resident #1 could have wiggled themselves down in bed and out of reach of the call light. LPN #8 stated she expected staff to keep call lights in reach of all residents. An observation on 07/16/2026 at 3:42 PM revealed Resident #1 lying on their back in bed with their eyes open. The observation revealed the pressure pad call light was sitting on the bed beside the resident's head on the left side of the mattress out of reach of the resident. During an interview on 07/17/2026 at 12:46 PM, LPN #6 stated she expected call lights to be kept in reach of all residents. LPN #6 stated it was not appropriate to have the pressure pad call light attached to the privacy curtain because Resident #1 would not be able to reach it. During an interview on 07/17/2026 at 1:21 PM, Certified Nursing Assistant (CNA) #7 stated that call lights should be in residents' reach at all times. CNA #7 stated the call light touch pads should have been placed by Resident #1's arm so the resident could reach it. CNA #7 stated Resident #1 could not reach a call light touch pad placed at the top of the bed beside their head, and the resident could not reach a call light touch pad that was attached to the privacy curtain. The CNA stated that neither placement was appropriate for Resident #1. During an interview on 07/17/2026 at 1:32 PM, the Director of Nursing (DON) stated that she expected call lights to be kept in reach of the resident at all times. The (continued on next page)		

Department of Health & Human Services
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375436	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER Willow Creek Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 West Noble Guthrie, OK 73044	
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON stated Resident #1 could use a touch pad call light, but the resident could not reach a call light touch pad positioned beside their head. The DON stated that Resident #1 could not reach a call light touch pad hanging off the top or side of the bed or attached to the privacy curtain. The DON stated none of those were acceptable places to place a call light. During an interview on 07/17/2026 at 2:09 PM, the Administrator stated that she expected call lights to be within residents' reach at all times. The Administrator stated Resident #1 could not reach a call light at the top of the bed, hanging over the top or side of the bed, or attached to the privacy curtain, and those were not appropriate places for a call light.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview, record review, and facility policy review, the facility failed to complete preadmission screening and resident reviews (PASARRs) for residents with a newly diagnosed mental illness for 3 (Residents #7, #42, and #48) of 3 sampled residents reviewed for PASARR. Findings included: A facility policy titled, Resident Assessment - Coordination with PASARR Program, dated 10/2025, indicated, 7. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. 1. A Resident Face Sheet indicated the facility admitted Resident #7 on 10/02/2024. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of delusional disorders, anxiety disorders due to known physiological condition, and depression. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/02/2025, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 1, which indicated the resident had severe cognitive impairment. The MDS indicated that the resident received antipsychotic and antidepressant medications during the assessment's even-day look-back period. A significant change MDS, with an ARD of 10/27/2025, revealed Resident #7 had severe impairment in cognitive skills for daily decision-making and had short-term and long-term memory problems per a Staff Assessment of Menal Status (SAMS). The MDS indicated that the resident received antipsychotic, antianxiety, and antidepressant medications during the assessment's seven-day look-back period. Resident #7's diagnosis list revealed that the list included anxiety disorders due to known physiological condition with an effective date of 06/04/2025, and depression with an effective date of 12/24/2025. Resident #7's record revealed no new PASARR was completed for the newly identified mental health diagnoses on 06/04/2025 or 12/24/2025. During an interview on 07/15/2026 at 2:59 PM, the Director of Nursing (DON) stated she was the one that completed the PASSARs, and she should have completed a new PASSAR for Resident #7 when they had a new mental health diagnosis of anxiety and depression. During an interview on 07/17/2026 at 1:19 PM, the Administrator stated she expected the staff to complete the PASSARs for a new mental health diagnosis. 2. A Resident Face Sheet indicated the facility admitted Resident #42 on 10/13/2025. According to the Resident Face Sheet, the resident had a medical history that included a diagnosis of dysthymic disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/28/2026, revealed Resident #42 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident received antianxiety and antidepressant medications during the assessment's seven-day look-back period. Resident #42's diagnosis list revealed that the list included dysthymic disorder with an effective date of 02/14/2026. Resident #42's record revealed no new PASRR was completed for the newly identified mental health diagnosis on 02/14/2026. During an interview on 07/15/2026 at 3:11 PM, the Director of Nursing (DON) stated that she should have completed a new PASSAR for Resident #42 when they had a new mental health diagnosis. During an interview on 07/17/2026 at 1:19 PM, the Administrator stated she expected the staff to complete the PASSARs for a new mental health diagnosis. 3. A Resident Face Sheet indicated the facility admitted Resident #48 on 09/19/2025. According to the Resident Face Sheet, the resident had a medical history that included a diagnosis of major depressive disorder. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/25/2025, revealed Resident #48 had severe impairment in cognitive skills for daily decision-making and had short-term and long-term memory problems per a Staff Assessment of (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Mental Status (SAMS). The MDS indicated the resident received antianxiety and antidepressant medications during the assessment's seven-day look-back period. Resident #48's diagnosis list revealed that the list included major depressive disorder with an effective date of 09/25/2025. Resident #48's record revealed no new PASARR was completed for the newly identified mental health diagnosis on 09/25/2025. During an interview on 07/15/2026 at 3:20 PM, the Director of Nursing (DON) stated she should have completed a new PASSAR for Resident #48 when they had a new mental health diagnosis. During an interview on 07/17/2026 at 1:19 PM, the Administrator stated she expected the staff to complete the PASSARs for a new mental health diagnosis.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview, record review, and facility policy review, the facility failed to ensure preadmission screening and resident reviews (PASARRs) were accurate for 2 (Resident #42 and Resident #48) of 3 sampled residents reviewed for PASARR. Findings included: A facility policy titled, Resident Assessment - Coordination with PASARR Program, dated 10/2025, indicated, This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. 1. A Resident Face Sheet indicated the facility admitted Resident #42 on 10/13/2025. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of anxiety disorder and depression. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/26/2025, revealed Resident #42 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident received antianxiety and antidepressant medications during the assessment's seven-day look-back period. Resident #42's diagnoses list revealed that the list included anxiety disorder and depression disorder with an effective date of 10/13/2025. Resident #42's Nursing Facility Level of Care Assessment, dated 10/16/2025, revealed that staff marked No on the resident's Level I PASRR [PASARR] Screen for evidence of serious mental illness, a diagnosis of serious mental illness, and a recent history of mental illness. During an interview on 07/15/2026 at 3:11 PM, the Director of Nursing (DON) stated that the admitting diagnoses of anxiety and depression should have been on Resident #42's PASARR. During an interview on 07/17/2026 at 1:19 PM, the Administrator stated she expected the staff to make sure the PASARRs on admission were correct. 2. A Resident Face Sheet indicated the facility admitted Resident #48 on 09/19/2025. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of anxiety disorder and depression disorder. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/25/2025, revealed Resident #48 had severe impairment in cognitive skills for daily decision-making and had short-term and long-term memory problems per a Staff Assessment of Mental Status (SAMS). The MDS indicated the resident received antianxiety and antidepressant medications during the assessment's seven-day look-back period. Resident #48's diagnoses list revealed that the list included anxiety disorder and depression disorder effective on 09/19/2025. Resident #48's Nursing Facility Level of Care Assessment, dated 09/29/2025, revealed that staff marked No on the resident's Level I PASRR [PASARR] Screen for evidence of serious mental illness, a diagnosis of serious mental illness, and a recent history of mental illness. During an interview on 07/15/2026 at 3:20 PM, the Director of Nursing (DON) stated that Resident #48's PASARR should have reflected the resident's mental health diagnoses. During an interview on 07/17/2026 at 1:19 PM, the Administrator stated she expected the staff to make sure the PASARRs on admission were correct.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on interview, and facility document review, the facility failed to complete daily nurse staffing data for each shift to include the facility census, total number of licensed and unlicensed staff, and the actual hours worked by licensed and unlicensed staff who were directly responsible for residents' care for 30 (06/14/2026 through 07/13/2026) of 30 days reviewed for staffing. Findings included: The facility's posted daily nurse staffing data for 06/14/2026 through 07/13/2026 revealed the postings did not include the facility census, total number of licensed and unlicensed staff, and the actual hours worked by licensed and unlicensed staff. During an interview on 07/13/2026 at 10:15 AM, the Assistant Director of Nursing (ADON) stated she had prepared the nurse staffing information and was responsible for the posting.		