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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455478	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy Creek Wellness & Rehabilitation	2501 Maple Ave Waco, TX 76707

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to keep residents free from misappropriation of property for 2 of 6 residents (Resident #1 and Resident #2) reviewed for misappropriation in that: On 1/30/2025 the facility discovered Resident #1 had 60 tablets of 7.5/325 mg hydrocodone tablets missing On 2/2/2026, the facility discovered Resident #2 had 30 tablets of 10 mg hydrocodone missing This failure could place residents at risk of not receiving the intended therapeutic benefit of the medications and could result in worsening or exacerbation of chronic medical conditions, and hospitalization. Findings included: Resident #1 Review of Resident #1's face sheet dated 2/5/2026 reflected a [AGE] year-old female admitted on [DATE] with diagnoses that included: hemiplegia and hemiparesis following cerebral infarction (weakness and paralysis following a stroke), contracture right hand, contracture left hand, vascular dementia (decline in cognitive function caused by impaired blood flow to the brain), and chronic pain syndrome. Review of Resident #1's quarterly MDS assessment dated [DATE], reflected she was rarely/never understood and had both short term and long-term memory problems. Further, it reflected her cognitive skills for daily decision making were severely impaired Review of Resident #1's care plan dated 2/6/2026 reflected: Focus: I require pain management [related to] diabetic neuropathy, contractures, deconditioning, and muscle spasms; Medication: Baclofen, Gabapentin, Hydrocodone with interventions of at risk for increased pain related to a drug discrepancy; administer analgesia per orders. Give 1/2 hour before treatments or care. Review of Resident #1's physician's orders reflected an active order for:Hydrocodone-Acetaminophen Oral Tablet 7.5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet via PEG-Tube three times a day for pain -Order Date- 01/06/2026 Review of Resident #1's narcotic count sheet reflected on 1/6/2026 64 tablets were received by LVN A Review of pharmacy manifest dated 1/5/2026 reflected 124 tablets of Hydrocodone-Acetaminophen Oral Tablet 7.5-325 MG were received for Resident #1 by LVN A. Resident #2 Review of Resident #2's face sheet dated 2/6/2026 reflected a [AGE] year-old male admitted on [DATE] with diagnoses that included: paraplegia (partial or complete paralysis of the lower half of the body), Type 2 Diabetes (blood sugar regulation disorder), heart disease, muscle wasting and atrophy, and major depressive disorder. Review of Resident #2's quarterly MDS assessment reflected he had a BIMS of 14 suggesting no cognitive impairment. Review of Resident #2's care plan dated 2/6/2026 reflected the Focus: I am at risk for pain secondary to muscle spasms [related to] paraplegia secondary to a spinal injury from a [gun shot wound] and [related to] neuropathy secondary to diabetes complications. Medication: Tylenol #3, Gabapentin, Biofreeze with interventions of Provide PRN medications as indicated. Review of Resident #2's physician's orders reflected an active order for Hydrocodone-Acetaminophen Oral Tablet 10-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for pain -Order Date- 12/28/2025. Review of Resident #2's narcotic count sheet for January reflected on 1/5/2026 60 tablets of tablets of Hydrocodone-Acetaminophen Oral Tablet 10-325 MG were received an unknown staff - signature missing. Review 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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Pharmacy manifest dated 1/5/2026 reflected 90 tablets of Hydrocodone-Acetaminophen Oral Tablet 10-325 MG were received for Resident #2 by LVN B. During an interview on 2/6/2026 at 9:30 am, the DON stated a nurse went to reorder Resident #1's narcotic medication and the pharmacy told her it was too soon. She investigated and discovered that LVN A had received the Hydrocodone-Acetaminophen Oral Tablet 7.5-325 MG on the narcotic count sheet, and the quantity was changed from 124 to 64 tablets. The facility suspects that LVN A was the one that made the change but there were no witnesses. She stated Resident #1 did not go without pain medication at that time. The DON stated while they were reviewing the narcotic count sheets, they discovered Resident #2 was missing 30 tablets of Hydrocodone-Acetaminophen Oral Tablet 10-325 MG. She stated there was no name written in the received box on the narcotic count sheet, just a date and an amount, but the handwriting looked like LVN A. Again, there were no witnesses. Resident #2 did not go without pain medication at that time either. She stated she interviewed LVN B, who received Resident #2's narcotic medication from the pharmacy and she stated she handed the medication off to LVN A. She stated nursing staff were following the existing policy at that time but since then, they have changed their policy on how narcotic medications will be received and distributed to the medication carts. The new process requires two nurses to receive medications and two nurses to put the medications in the cart - both nurses will sign and date the narcotic count sheets when received and put away. During an interview on 2/6/2026 at 1:51 pm, the ADM stated his expectations regarding the receipt of narcotics was that two nurses will sign for delivery, both nurses go to the cart and put meds away, then both log it, secure it and sign the sheet. They should make sure the count sheet was accurate with no cross outs and if there were any changes made to the narcotic label on the count sheet, they should immediately notify the DON or ADM. He stated when narcotic medications are not available for residents, they might be unable to control their pain or control their anxiety - they might need it to calm down. During an interview on 2/6/2026 at 2:51 pm, the MD stated his expectations regarding the management and receipt of narcotics in general that there would be zero errors, no diversion and no missing medications. He stated with diversion there was a potential of misuse, or an overdose, a danger of meds not being available and a lack of pain control for the residents. He stated he is pleased with the facility's implementation of a different process, and they recently changed pharmacies - the new pharmacy's system has more up to date technology, and it was a good move. During an interview on 2/6/2026 at 3:15 pm, the DON stated her expectations regarding the receipt of narcotics was that staff would adhere to the rules regarding getting meds from the pharmacy, storing of meds, passing keys and signing the narcotic sheets as required. She stated when narcotic medications are not available residents could have increased pain or anxiety. During an interview on 2/6/2026 at 3:40 pm, Resident #2 stated he was aware of the missing medications, but it did not affect him in any way. He stated he had no concerns with care at the facility, and his pain was being managed. Attempts to reach LVN A by phone calls and text for an interview were unsuccessful. Review of facility policy Abuse, Neglect and Exploitation dated 4/11/2025 reflected It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Definition:Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent. Policy Explanation and Compliance Guidelines:1. The facility will develop and implement written policies and procedures that:a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property;b. Establish policies and procedures to investigate any such allegations; andc. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriate of resident property, reporting procedures, and dementia management and resident abuse prevention