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	07/01/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to immediately inform the resident, consult with the resident's physician and notify, consistent with his or her authority, the resident representative(s) when there was a significant change in the resident's physical, mental, or psychosocial status in either life-threatening condition of clinical complications for one of eight residents (Resident #1) reviewed for resident rights. The facility failed to notify Resident #1's FM when she refused meals on 6/20/2026, 6/21/2026, 6/22/2026, 6/23/2026, 6/24/2026, and 6/25/2026. This failure could place residents at risk of a decreased quality of life and risk of not having their responsible party represent them in medical and care decisions.Findings include: Review of Resident #1's face sheet dated 6/30/2026 reflected she was a [AGE] year-old female admitted on [DATE] with diagnoses that included: type 2 diabetes (blood sugar regulation disorder), chronic kidney disease (progressive decline of kidney function), chronic obstructive pulmonary disease (a progressive lung condition that causes breaking difficulties), chronic pain, and cognitive impairment (problems with memory, attention, language or judgment that go beyond normal aging). Review of Resident #1's quarterly MDS assessment reflected a BIMS score of 2 suggesting severe cognitive impairment. Review of Resident #1's physician's orders reflected an order dated 4/10/2026 for hospice to evaluate and start treatment. Review of Resident #1's Care plan for May 2026 reflected the focus: Resident refuses to eat meals or drink fluids consistently, placing self at risk for dehydration, weight loss and nutritional deficiencies. Interventions included: Assist [resident] with meals, document meal and fluid intake daily, engage resident in social dining, and involve resident in food choices. Review of Resident #1's Progress notes dated 6/20/2026 to 6/30/2026 reflected no nursing entries related to refusal of meals or that FM was notified of refusals. Review of Resident #1's Plan of Care [sic] Response History reflected resident refused meals on:6/20/2026 - lunch6/21/2026 - breakfast6/22/2206 - breakfast and dinner6/23/2026 - all meals6/24/2026 - breakfast and lunch6/25/2026 - breakfast and lunch. During an interview on 6/30/2026 at 2:18 pm, Hospice Nurse (HN) stated Resident #1 will frequently refuse care, bathing, wound care, medication and meals. She stated Resident #1's capacity to refuse is questionable. When staff try to provide care, she will get upset, yell, curse at staff and then refuse care. HN stated she has seen staff bringing meals in and offering it to Resident #1 and she will refuse, when they try to feed her, she gets upset. She stated since Resident #1 has been on hospice services she has gone from eating to not eating much at all,. She stated this is was part of the process of overall natural decline; Resident #1 is was being asked if she is was hungry and she says no. HN stated she has tried to feed Resident #1 herself and she has refused to eat. HN stated she was not aware the facility was not notifying the FM when meals were refused. During an interview on 7/1/2026 at 1:17 pm, FM stated they were not aware Resident #1 had been refusing so many meals lately. She stated when FM was notified previously, they would try to come up to the facility with food and try to get the resident to eat. FM stated they have not gotten any calls in at least a month that Resident #1 was refusing meals. FM stated because of Resident #1's dementia she will get irritated and won't want to eat. She stated they do have a camera in the room and if they see her (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	refusing a meal, the family will intervene and bring her food. FM stated if they don't catch it on the camera, they have no way of knowing she has refused, because the facility is not notifying them. FM stated she had no idea Resident #1 had missed that many meals since 6/20/2026 and she was very upset the facility had not called. During an interview on 7/1/2026 at 10:16 am, MD stated she was familiar with Resident #1 who was on hospice and frequently refused care. She stated it is normal for a resident near end of life to refuse care and refuse meals. She stated staff should be documenting refusals of care or eating and notifying appropriate FM and nursing staff. She stated she noted Resident #1 was weighed in April, but typically once they go on hospice she does not feel they need weight checks. MD stated she was aware that Resident #1 was refusing to be weighed. During an interview on 7/1/2026 at 1:52 pm, DON stated if a resident refused a meal, staff should offer a supplement and let the nurse know. She stated if the resident still refuses when the nurse tries, it should be documented in the EMR and call FM. She stated Resident #1's FM wasn't to be notified if there are any refusals and staff need to notify FM. DON stated she used to be able to go in there and get Resident #1 to agree to care, agree to would wound care, agree to eat a meal, but now she will not do anything - Resident #1 doesn't want to be bothered, she wants to be left alone. Review of facility policy. , Resident Rights revised 8/2020 reflected: All residents have a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility including those specified in this policy. The Facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment, that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The Facility will protect and promote the rights of the resident and provide equal access to quality of care regardless of diagnosis, severity of condition, or payment source. C. Choose a physician and treatment and participate in decisions and care planning, including involving representatives and considering personal and cultural preferences;D. Be fully informed and participate in his/her treatment including being fully informed in a language that he or she can understand of his/her total health status including his/her medical condition;

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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 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 that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately but not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for one of eight (Resident #2) residents reviewed for reporting abuse and neglect. The nursing facility failed to report to the state agency that Resident #2 was missing on 6/28/2026 for 30-40 minutes resulting in sunburn to his scalp, arms, legs and face. This failure could place residents at risk of serious injuries from falls, heat-related emergencies from heat exposure and injuries from traffic accidents.Review of facility policy Abuse Prevention and Prohibition Program dated revised October 24, 2022, reflected I. Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property. D. Facility will report allegations of. use, neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property, or other incidents that qualify as a crime.i. Immediately but no later than 2 hours after forming the suspicion - if the alleged violation involves abuse or results in serious bodily injury to the state surveyagency, adult protective services, law enforcement, and the Ombudsman (if applicable per state regulation).ii. No later than 24 hours after forming the suspicion - if the alleged violation (e.g. misappropriation of property, neglect) does not involve abuse and does not result in serious bodily injury to the state survey agency, adult protective services, law enforcement, and the Ombudsman. Review of Provider Letter PL 2024-14, titled Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Other Incidents that a Nursing Facility (NF) Must Report to the Health and Human Services Commission (HHSC) with date issued: August 29, 2024 reflected: 2.1 Incidents that a NF Must Report to HHSC A NF must report to CII the following types of incidents, in accordance with applicable state and federal requirements: Abuse Neglect Exploitation Death due to unusual circumstances4 A missing resident Misappropriation Drug theft Suspicious injuries of unknown source Fire Emergency situations that pose a threat to resident health and safety8 Communicable disease situations that are an unusual or abnormal event that poses a threat to resident health and safety Review of facility policy Wandering and Elopement dated revised 8/2020 reflected: PurposeTo enhance the safety of residents of the facility and VII. Response to Resident ElopementG. The facility will make necessary reports to state agencies. Resident #2 Review of Resident #2's face sheet dated 6/30/2026 reflected he was a [AGE] year-old male admitted on [DATE] with diagnoses that included: Alzheimer's disease (a progressive brain disorder that destroys memory and thinking skills), anxiety disorder, hyperlipidemia (elevated levels of cholesterol in the blood), major depressive disorder (depression), and insomnia (inability to sleep). Review of Resident #2's quarterly MDS assessment dated [DATE] reflected he had a BIMS score of 99 indicating he was unable to complete the interview. Under section C - Cognitive patterns staff indicated Resident #2 had both long term and short-term memory problems. Review of Resident #2's annual MDS assessment dated [DATE] reflected he had a BIMS score of 8 suggesting moderate cognitive impairment. Review of Resident #2's progress notes on 6/30/2026 at 1:08 pm reflected no progress notes for 6/28/2026 regarding resident being missing from the facility. Review of Resident #2's skin assessment dated [DATE] at 2:02 pm, reflected the following: Type of skin impairment: top of scalp - sunburn; other - bilateral forearms; other - bilateral lower extremities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's elopement assessment dated [DATE] reflected a score of 1 indicating a category or of no risk. During an interview on 6/28/2026 at 12:00pm Resident #2 stated he wanted to go for a walk to go to church and the gate was open, so he left. Stated he was not hurt just sunburned. He stated he got a ride back with a staff person and then they checked him over. He stated they gave him drinks and watched him. During an observation on 6/28/2026 at 12:00pm Resident #2 was observed to have redness to the back of his neck, above the collar line and below the hairline, redness on head/face, and redness on his arms; legs were not visualized as Resident #2 had pants on. During an interview on 6/28/2026 at 1:14 pm, FM stated they had arrived at the facility on 6/28/2026 at 12:30 pm to visit Resident #2. They went to his room, and he was not in his room. FM checked with staff and they were not able to locate Resident #2 in the building. FM stated about 20 minutes later Resident #2 arrived back at the facility, after being delivered by another staff member. FM stated Resident #2 had been at the facility since September of 2025 and had never left the building. During an interview on 6/30/2026 at 12:30 pm, DON stated she was aware of Resident #2 going missing on 6/28/2026. She stated Resident #2 was assessed when he returned to the building and had some mild sunburn but no serious injuries and did not complain of any pain or injuries. DON stated Resident #2 had no history of being exit seeking or saying he wanted to leave the facility. She stated his recent elopement assessment indicated he was low risk. DON stated with Resident #2 leaving the facility and going missing - there was serious potential for harm - he could have been hit by a vehicle, he could have stepped off a curb and fell, dehydration, heat exhaustion; could have gotten, heat stroke and became disoriented. She stated any and all of those could have been life threatening. During an interview on 6/30/2026 at 3:24 pm, Nurse A stated she was working on day shift on 6/28/2026 when Resident #2 went missing. She stated he had been seen walking back and forth to the dining room about 12:10-12:15 pm, then when they went to deliver his lunch tray in his room, they could not find him. She stated they started looking through the facility for him and could not locate him, but about that time, HKPS called her and told her she found him down the road and was bringing him back in her car. She stated she assessed Resident #2 when he got back and noted some light sunburn to his arms, face, scalp and legs, but no other injuries. She stated she called the NP and notified her of what happened and NP gave orders for over-the-counter aloe to treat his sunburn, some labs and a urinalysis. The NP also told her to make sure Resident #2 was encouraged to hydrate. She stated by the time all this was done, it was close to shift change, so she passed on all the information to the oncoming nurse but forgot to put in any progress notes about the incident. She stated she completed a skin assessment and noted he had sunburn to both arms and the top of his head and face. During an interview on 6/30/2026 at 5:07 pm, HKPS stated on 6/28/2026 at about 12:45 pm, she saw Resident #2 while she was driving down the street away from the facility. She stated she found him on the opposite side of the street from the facility several blocks down. HKPS stated she pulled over in a parking lot and asked him where he was going, and he said he was going for a walk. She stated she asked Resident #2 to get in her car so she could take him back and he did. HKPS stated she called the facility and spoke to the charge nurse, Nurse A, and told her she had Resident #2 and was bringing him back to the facility. She stated Resident #2 was wearing a white t-shirt and long flannel type lounge pants. She stated he looked hot but did not complain of any injuries. During an interview on 7/1/2026 at 8:48 am, ADM stated Resident #2's incident was not an elopement - he failed to sign out. ADM also stated resident had never signed themselves out before and had only left with family. ADM stated, technically he was missing for about 30-40 minutes. She stated a missing resident incident should have been reported to the state agency and it was her responsibility to report it. She stated she spoke to the corporate consultant, and they decided it didn't need to be reported because it wasn't an elopement. She stated per their policy, any incident that occurs, they go to their consultant at corporate for guidance and that is what she did. ADM stated there were several environmental risk factors with Resident #2 being missing including the extreme heat, the sun, and traffic conditions on a 4-lane roadway. ADM stated there was a potential for (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	serious injury due to the environmental factors and the timing was fortunate in that there wasn't much traffic and a staff member saw him and brought him back to the facility quickly. During an interview on 7/1/2026 at 10:16 am, MD stated she was never notified of Resident #2 going missing on 6/28/2026, but the NP was the provider that was notified and gave orders for Resident #2. MD stated Resident #2 had a diagnosis of Lewy Body Dementia and cognition levels could fluctuate so much from day to day and even during the day. She stated her concerns for Resident #2 being missing and out in the heat in the middle of the day for 30-40 minutes would be dehydration, heat exhaustion, he could have gotten hurt from falling and injuring himself. She stated he could have been seriously hurt, and it was not a good situation for him to be in with his mental status. MD stated he could have been seriously injured being out in the heat in his confused state and some injuries could have potentially been life threatening. During an interview on 7/1/2026 at 11:23 am, NP stated she was aware of the event with Resident #2 on 6/28/2026. She stated nursing staff called her and she gave verbal orders for topical aloe vera for his sunburn, told staff to make sure he hydrates and get a urinalysis and labs done. She stated Resident #2's labs and urinalysis came back all within normal parameters. She stated Resident #2 has been very stable for a long time. She stated the potential harm to the resident by walking away from the facility during the day would have been extreme heat related conditions - heat exhaustion, heat stroke, dehydration which could lead to electrolyte imbalances. She added, in extreme measures these could lead to heart failure, which in extreme circumstances could lead to death.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 resident (Resident #2) of 3 residents reviewed for accidents and hazards The nursing facility failed to ensure there was appropriate supervision to prevent Resident #2 from going missing on 6/28/2026 for 30-40 minutes resulting in sunburn to his scalp, arms, legs and face. This failure could place residents at risk of serious injuries from falls, heat-related emergencies from heat exposure and injuries from traffic accidents.Findings include: Review of Resident #2's face sheet dated 6/30/2026 reflected he was a [AGE] year-old male admitted on [DATE] with diagnoses that included: Alzheimer's disease (a progressive brain disorder that destroys memory and thinking skills), anxiety disorder, hyperlipidemia (elevated levels of cholesterol in the blood), major depressive disorder (depression), and insomnia (inability to sleep). Review of Resident #2's quarterly MDS assessment dated [DATE] reflected he had a BIMS score of 99 indicating he was unable to complete the interview. Under section C - Cognitive patterns staff indicated Resident #2 had both long term and short-term memory problems. Review of Resident #2's annual MDS assessment dated [DATE] reflected he had a BIMS score of 8 suggesting moderate cognitive impairment. Review of Resident #2's progress notes on 6/30/2026 at 1:08 pm reflected no progress notes for 6/28/2026 regarding resident being missing from the facility. Review of Resident #2's skin assessment dated [DATE] at 2:02 pm, reflected the following: Type of skin impairment: top of scalp - sunburn; other - bilateral forearms; other - bilateral lower extremities. Review of Resident #2's elopement assessment dated [DATE] reflected a score of 1 indicating a category or of no risk. During an interview on 6/28/2026 at 12:00 pm Resident #2 stated he wanted to go for a walk to go to church and the gate was open, so he left. Resident stated he was not hurt just sunburned. He stated he got a ride back with a staff person and then they checked him over. He stated they gave him drinks and watched him. During an interview on 6/28/2026 at 1:14 pm, FM stated they had arrived at the facility on 6/28/2026 at 12:30 pm to visit Resident #2. They went to his room, and he was not in his room. FM checked with staff and they were not able to locate Resident #2 in the building. FM stated about 20 minutes later Resident #2 arrived back at the facility, after being delivered by another staff member. FM stated Resident #2 had been at the facility since September of 2025 and had never left the building. During an interview on 6/30/2026 at 12:30 pm, DON stated she was aware of Resident #2 going missing on 6/28/2026. She stated Resident #2 had been seen by staff about 12:15 and was discovered missing when they delivered his lunch tray to his room around 12:30pm. DON stated Resident #2 had no history of being exit seeking or saying he wanted to leave the facility. She stated his recent elopement assessment indicated he was low risk. DON stated with Resident #2 leaving the facility and going missing - he could have been hit by a vehicle, he could fall (resident had no history of falls), dehydration, or heat exhaustion. During an interview on 6/30/2026 at 3:24 pm, Nurse A stated she was working on day shift on 6/28/2026 when Resident #2 went missing. She stated he had been seen walking back and forth to the dining room about 12:10-12:15 pm, then when they went to deliver his lunch tray in his room, they could not find him. She stated they started looking through the facility for him and could not locate him, but about that time, HKPS called her and told her she found him down the road and was bringing him back in her car. She stated she completed a skin assessment and noted he had sunburn to both arms and the top of his head and face but no other injuries. During an interview on 6/30/2026 at 5:07 pm, HKPS stated on 6/28/2026 at about 12:45 pm, she saw Resident #2 while she was driving down the street away from the facility. She stated she found him on the opposite side of the street from the facility several blocks down. HKPS stated she pulled over in a parking lot and asked Resident #2 to get in her car so she could take him back and he did. HKPS stated she called the facility and spoke to the charge nurse, Nurse A, and told her she had Resident #2 and was bringing him back to the facility. During an (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 7/1/2026 at 8:48 am, ADM stated she was aware of Resident #2's incident on 6/28/2026. She stated Resident #2 had no history of exit seeking behaviors or expressing a desire to leave. She stated he was able to walk out the magnetic gate on the patio because someone failed to close it properly. She stated they had Maintenance look at the gate after the incident, and it was functioning properly ADM stated they were in the process of changing out the keypad on the gate to make it more secure and keep staff from using it as an entrance or exit. She stated in-services with staff have been done to ensure the patio gate is not used by staff. During an interview on 7/1/2026 at 9:15 am, the Maintenance Director stated he was aware of the incident on 6/28/2026 when Resident #2 walked out of the patio gate. He stated he came up to the facility on 6/28/2026 and inspected the gate and it was working properly. He stated the only thing he could think of is maybe a staff member went through the gate and did not let make sure it closed and the magnetic latch caught. He stated they were in the process of changing out the keypad right now and upgrading the locking mechanism. He added that only leadership would have the code to prevent staff from using the gate to go in and out. During an interview on 7/1/2026 at 10:16 am, MD stated she was never notified of Resident #2 going missing on 6/28/2026, but she was told the NP was notified and gave orders for Resident #2. She stated to her knowledge Resident #2 did not have any wandering or exit seeking behaviors and had a low elopement risk score when he was assessed back in March 2026. MD stated Resident #2 had a diagnosis of Lewy Body Dementia and cognition levels could fluctuate from day to day and even during the day. MD stated he could have been seriously injured being out in the heat in his confused state. During an interview on 7/1/2026 at 11:23 am, NP stated she was aware of the event with Resident #2 on 6/28/2026. She stated Resident #2 did not have a history of wandering or trying to leave the facility and had been stable for quite some time with no noted exit seeking behaviors. She added he had been assessed back in March 2026 for elopement and was a very low risk. She stated the potential harm to the resident by walking away from the facility during the day would have been extreme heat related conditions - heat exhaustion, heat stroke, dehydration which could lead to electrolyte imbalances. Review of facility policy Wandering & Elopement revised 8/2020 reflected: The Facility will identify residents at risk for elopement and minimize any possible injury as a result of elopement. Further: I. The Licensed Nurse, in collaboration with the Interdisciplinary Team (IDT), will assess residents upon admission, readmission, quarterly, and upon identification of significant change in condition to determine their risk of wandering/elopement.II. The resident's risk for elopement and preventative interventions will be documented in theresident's medical record, and will be reviewed and re-evaluated by the IDT upon dm ssreadmission, quarterly, and upon change in condition. A facility policy on Supervision of Residents was requested on 6/30/2026 at 10:41 and again on 7/1/2026 at 2:47 pm but not provided prior to exit on 7/1/2026.