STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675350	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowcreek Rehab and Nursing	4934 S 7th St Abilene, TX 79605

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to 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 and treat residents with respect and dignity for 3 of 12 (Residents # 62, Resident # 45, and Resident # 22) residents reviewed for dignity.The facility failed to prevent CNA E from standing over Resident# 62, Resident # 45, and Resident # 22 while assisting residents with eating their meal in the dining area.The facility failed to prevent CNA E from referring to Resident# 62, Resident # 45, and Resident # 22 who needed assistance with meals, as feeders.These failures could affect residents that require assistance with eating by placing them at risk of diminished quality of life and loss of their sense of self self-worth.BThe findings included:Review of Resident #62's Face Sheet dated 05/06/2026, reflected an [AGE] year-old-female admitted to the facility on [DATE] with diagnoses including the following: dementia (a general term for loss of memory, language, and problem solving skills severe enough to interfere with daily life, muscle wasting and weakness, anxiety disorder (Persistent worry and fear that interferes with daily life lasting for months).Review of Resident #62's Quarterly MDS, dated [DATE] reflected a BIMS score of 6 indicating severe cognitive impairment. The resident had difficulty focusing her attention, required substantial to maximal assistance with eating, but did not have a significant weight loss or gain.Review of Resident #62's Care Plan dated 4/18/26 reflected the following problems: Resident is on a Regular diet regular texture with thin liquids and is at nutritional and hydration risk related to dementia.Review of Resident #45's Face Sheet dated 05/06/2026 reflected a [AGE] year-old-female admitted to the facility on [DATE] with diagnoses including the following: adjustment disorder with depressed mood (excessive reaction to stress that involve negative thoughts, strong emotions, and changes in behavior), protein calorie malnutrition (a condition resulting from inadequate intake of protein and calories) dementia (a group of symptoms that affect thinking, memory, and social abilities), and anxiety disorder (a mental health condition characterized by excessive worry about every day issues affecting daily functioning and quality of life).Review of Resident #45's Quarterly MDS, dated [DATE] reflected that she was unable to complete the BIMS test, and had severe cognitive impairment with a long- and short-term memory problem. The resident had difficulty focusing her attention, required setup and cleanup assistance with eating, but did not have a significant wt loss or gain.Review of Resident #45's Care Plan dated 01/13/2026reflected the following problems: Resident is on a Regular diet regular texture with thin liquids and is at nutritional & hydration risk related to dementia. Resident has ADL Self Care and requires setup and clean up assistance with feeding, Resident is on a Regular with mech-Soft texture diet thin liquids and at nutritional and hydration risk related to dementia. Review of Resident #22's Face Sheet dated 05/06/2026 reflected a [AGE] year-old-female admitted to the facility on [DATE] with diagnoses including the following: obesity, chronic oral aphthae (chronic ulcerations of the oral cavity and mouth that are painful), and decreased mobility and major depressive disorder with psychosis (characterized by deep depression and loss of touch with reality).Review of Resident (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#22's Quarterly MDS, dated [DATE] reflected she was unable to complete a BIMS assessment , had a severe cognitive impairment with a long and short term memory problem. She continually exhibited inattention, and continually displayed disorganized thinking. She required maximal assistance with eating, had a significant weight loss of 5 percent or more in the last 30 days or 10 percent in the last 6 months and required maximal assistance with eating. Her weight was 208.Review of Resident #22's Care Plan dated reflected the following problems: Resident will grab food off of other residents' trays, from the food cart, and the trash can. Resident is on a Regular with mechanical soft texture diet thin liquids and at nutritional and hydration risk related to dementiaIn an observation on 05/04/2026 at 12:15 p.m., of the lunch meal in the secure unit dining room, CNA C was observed standing over Resident #62 and assisting her with eating her meal by placing food in her mouth with a utensil. Resident # 62 had to be redirected constantly in order to keep her seated at the bedside table where she was seated in the dining room.In an interview an observation on 05/05/2026 at 12/20/2026 at 12/30/2026 12:30 pm CNA E s was standing over a group of 5 residents in a corner of the dining room and was assisting Resident # 62, Resident # 45, and Resident # 22 eating their lunch meal. She stated there were 2 staff in memory care that day and there were usually 3 staff. CNA E stated there were 9 feeders , in the dining area for all meals. CNA E stated that she could not think of anything that she had done wrong during the meal service. She stated she did not think that there could have been a negative outcome for referring to resident's that needed assistance with eating as feeders or by standing over them and moving from one resident to another.In an interview on 5/05/2026 at 12:45 p.m. LVN F said staff should not stand over residents when they were assisting residents with their meals, they should sit at eye level and speak to the residents when they were feeding them. She stated residents should have been called by their preferred name and not nick names such as mama or labels such as feeders. She stated they could affect the residents by making them feel as if they were not treated as respected individuals.In an interview on 5/05/2026 at 12:30 p.m. the DON said staff should not stand over residents when they were assisting residents with their meals, they should sit at eye level and speak to the residents when they were feeding them. She stated resident's should be called by their preferred name and not nick names such as mama or labels such as feeders. The DON said it was a dignity issue. She stated she would do an in-service with CNA Eand all staff regarding feeding and do a competency check on all Staff for feeding a resident who cannot feed themselves.Record review of the policy dated February 12th, 2017, titled Promoting/ Maintaining Resident Dignity: dated 02/26/2020 did not mention dining.Record review of Resident Clinical skills check list titled Feeds client who cannot feed self-stated in part: Explains procedure to client speaking clearly, slowly, and directly maintaining face-to-face contact whenever possible. CNA sits in a chair facing the resident. Using spoon offers resident one bite of each food on tray telling the resident the content off each spoonful. CNA asks resident if they are ready for the next bite.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on interview and record review, the facility failed to ensure residents had the right to send and receive mail, and to receive letters, package and other materials delivered to the facility or the resident through a means other than a postal service, including the right to privacy of such communications for 5 of 5 residents (confidential residents) reviewed for resident rights.The facility failed to ensure staff distributed mail received on Saturdays to the residents. This failure could result in residents not receiving mail in a timely manner and a diminished quality of life.Findings included:During a confidential group interview on an undisclosed date and time, 5 of 5 members in the group stated they did not receive mail on Saturdays because the girls in the offices did not work on Saturdays. They stated the mail was delivered Monday through Friday.During an interview on 05/06/2026 at 1:52 p.m., the AD stated she was responsible for getting the mail for the residents during the week Monday through Friday. She stated before today there was no person that was assigned to get the mail on the weekends. She stated moving forward, the plan was for a nurse to go and get the mail out of the mailbox, separate the business office mail out and give the residents their mail on Saturdays. She stated she would come up to the facility on Saturday if needed to administer mail but had never been told to. During an interview on 05/06/2026 at 2:21 p.m., the DON stated she expected residents to get mail on Saturdays. She stated the facility was planning on having a Saturday nurse pass out mail on the weekend and the weekend supervisor to make sure the mail was passed out. She stated the facility only had one key for the mailbox and they were getting another one made for the weekend staff. She stated residents having to wait until Monday for their mail could possibly cause depression from not getting mail when expected.During an interview on 05/06/2026 at 2:54 p.m., the ADMN stated mail should have been delivered on Saturdays. He stated there was only one key and the AD had it. He stated moving forward, they would have a key made for the nurses working on Saturdays. He stated the Saturday nurse could then collect mail out of the mailbox and deliver it to the residents. He stated he was not aware the mail was not being delivered and no one had brought it to his attention. He stated no residents had complained about not receiving mail to him. He stated not delivering the mail could have caused residents to be upset about having to wait until Monday for their mail when they were expecting it on Saturday. Record review of facility policy titled, Resident Right to Privacy in Communication, dated 2/10/2021, reflected The facility will honor the resident's right to privacy in written communications including the right to: a. Send and promptly receive mail that is unopened.The social service designee, or another designated staff member, will ensure each resident receives any mail addressed to that particular resident promptly.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide maintenance services necessary to maintain a sanitary, and comfortable environment for 5 of 20 (room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], 104 and the East Conference Room) rooms observed for environmental conditions. The facility failed to ensure rooms 101,102, 103, 104 and the East side Conference Room sinks had hot water. These failures could place residents at risk for diminished quality of life, discomfort, and safety. Findings included: During an observation on 05/05/2026 at 12:16 p.m., East Side room [ROOM NUMBER] the water temperature in the sink with shared toilet room with room [ROOM NUMBER] hot water felt cold. The temperature was taken and the hot water temperature was 79.7 degrees F, after water was left running for 1 minute. During an observation on 05/05/2026 at 12:21 p.m., East Side room [ROOM NUMBER] the water temperature in the sink shared with room [ROOM NUMBER], the hot water felt cold. The temperature was taken and the hot water temperature was 78.4 degrees F, after water was left running for 1 minute. During an observation on 05/05/2026 at 3:03 p.m., East Side room [ROOM NUMBER] water temperature in the sink shared with room [ROOM NUMBER] the hot water felt cold. The temperature taken and the hot water temperature was 86.3 degrees F, after water was left running for 1 minute. During an observation on 05/05/2026 at 3:05 p.m., East Side room [ROOM NUMBER] water temperature in the sink shared with room [ROOM NUMBER] the hot water felt cold. The temperature was taken and the hot water temperature was 86.2 degrees F, after water was left running for 1 minute. During an observation on 05/05/2026 at 3:22 p.m., the East Side conference room at the end of the hallway's toilet room sink hot water was not hot. The temperature was taken and the hot water temperature was 87.0 degrees F, after water was left running for 1 minute. During an observation on 05/06/2026 at 9:23 a.m., East Side room [ROOM NUMBER] the water temperature in the sink shared with room [ROOM NUMBER] the hot water felt cold. Temperature taken and the hot water temperature was 66.3 degrees F, after water was left running for 1 minute. During an observation on 05/06/2026 at 9:29 a.m., East Side room [ROOM NUMBER] water temperature in the sink shared with room [ROOM NUMBER] the hot water felt cold. The temperature was taken and the hot water temperature was 77.3 degrees F, after water was left running for 1 minute. During an interview on 05/05/2026 at 12:11 p.m., LVN A stated she notified the maintenance director that morning verbally that the water was not coming up to temperature. She stated she did not know if the maintenance director had checked the water temperatures. She stated she would want water to be hot in the sink of the room if she resided at the facility. During an interview and observation on 05/06/2026 at 9:25 a.m., MA B stated she would expect hot water to be available in the bathroom. She stated that sometimes if you ran the cold water, it would help the water to flush through the lines and the hot water would get to the sink faster. She was observed running the cold water, and the hot water temperature did not improve. She stated she was not aware that the hot water was not working or how long it had not worked. During an interview on 05/06/2026 at 9:38 a.m., the maintenance director stated she was taking temperatures of the water in room weekly and had those logs. She stated she had not been told that the water was not hot in rooms 101-103 or 102-104. She stated last year, the facility had issues with the hot water being too hot. She stated the temperature needed to be between 100 and 110 in the resident rooms and shower rooms. She stated the facility had put in an aquastat (a device that senses and controls water temperature) to help regulate that the temperatures would not be too hot. She stated the facility used a loop system and if the hot water heater was not functioning the hot water in the shower would not be the correct temperature. She stated she would call the plumber to find out why the resident rooms at the end of the hall did not have hot water. During an interview on 05/06/2026 at 9:40 a.m., the Regional Clinical Nurse stated she would expect the water in the sinks in (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the restrooms to be hot. She stated the aquastat would not allow for the water to not get above 106 degrees but would not make the water not flow to the rooms on the end of the hallway. She stated a plumber was scheduled to look at the water situation that afternoon at 2:00 p.m. During an interview on 05/06/2026 at 2:54 p.m., the ADMN stated he expected residents to have access to hot water in the bathroom of their rooms. He stated the facility had plumbers out to correct the issue and he was told they would have to replace a check valve. He stated the maintenance director was checking the room temperatures weekly in all the rooms and had not had a temperature reading that was out of range. He stated he had not been informed of any resident rooms not having low water temperatures before this morning. He stated not having hot water could lead to residents being upset. Record review on 05/06/2026 of the facility's weekly water temperature logs, dated April 2026, reflected the water temperatures on the East Side of the building had been taken on 4/3/26, 4/10/26, 4/17/26, 4/24/26, and 4/30/26. Rooms 101 / 103's water temperatures ranged from 100 - 103 in April 2026. Rooms 102 / 104's water temperature ranged from 100 - 103 in April 2026. No temperatures observed were lower than 100. The administrator was asked for a policy on hot water on 05/06/2026 and a policy was not provided by exit.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that residents were free of a med error rate of 5% or greater for 3 (Resident #10, Resident # 20 and Resident #25) of 5 residents reviewed for medication administration. The facility failed to ensure the medication error rate (11.5%) was less than 5%. This failure placed residents at risk of incorrect doses of medications and optimal therapeutic response. Findings included: Resident #10 Record review Resident #10's face sheet dated 5/6/26 revealed a [AGE] year-old female with an admission date of 12/12/2024. She had an active diagnosis of Dysphagia (difficulty swallowing) following cerebral infarct. Record review of Resident #10's physician orders dated 05/05/26 documented the following order: Acetaminophen (Tylenol) Oral Tablet 500 mg . Give 2 tablets via PEG-Tube every morning and at bedtime. During an observation on 05/05/2026 at 9:00 AM LVN A gave Tylenol 160 mg/5 ml gave 30 ml. Resident #20 Record review of Resident #20's face Sheet dated 05/06/2026 revealed a 64 -year-old female with a most recent admission date of 11/17/2025. Resident had the following diagnosis: Diabetes Mellitus. Record review of Resident #20s Physician Orders dated 05/05/2026 revealed: Insulin Aspart Flex Pen Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Aspart) Inject 12 unit subcutaneously before meals for hyperglycemia Do not give if not eating or BS less than 60.Must give with 15minutes Inject as per sliding scale: if 151 - 200 = 3 units; 201 - 250 = 6 units; 251 - 300 = 9 units; 301 - 350 = 12 units; 351 - 400 = 15 units, subcutaneously before meals and at bedtime Inject subcutaneously before meals and at bedtime related to Diabetes. In an observation on 05/06/2026 at 10:34 AM, RN D checked Resident #20's blood glucose and obtained a reading of 317. Per resident sliding scale, orders stated (Blood sugar 301 -350 give 12 units Aspart Insulin) LVN gave Resident #20 12 units of Aspart insulin SQ and 12 units of Aspart Insulin to = 24 units . In an interview on 05/05/26 at 2:46PM with the Regional Nurse, she said her expectation for nurses was to check the resident's blood sugar and administer short acting insulin within 15 minutes of a meal and administer the correct dosage of all medications and the correct form according to the package label and the physicians orders. She said the adverse outcome for residents could be not getting the correct dose of insulin and low blood sugar. She stated she would in-service the RN D and other nursing staff. She stated she did not know why the errors occurred. She also stated that the nurse had rechecked the blood sugar before lunch and her blood sugar was 300. Resident #25 Record review on 05/06/2026 of Resident # 20's face sheet dated 05/06/26 revealed a 79- year old female with an admission date of 8/18/2025. She had a diagnosis of unspecified diastolic congestive heart failure (a condition that results when the heart's left ventricle stiffens and cannot relax normally preventing it from adequately filling with blood during heart beats Record review of Resident #25's physician orders dated 05/05/26 revealed an order for Metoprolol Tartrate 25 mg 1/2 tablet to equal 12.5 mg. twice daily po. During an observation on 5/5/25 at 9:00 a,m, LVN A gave Metoprolol Succinate (extended release) 1/2 to equal 12.5 mg tablet po. In an interview on 05/05/26 at 4:56PM with the DON, she said expected a fast-acting insulin that was administered per sliding scale according with the dosage indicated by the blood sugar reading that corresponded to the sliding scale no more than fifteen minutes before bedtime. She stated that failure to administer any medication to a resident in the correct form or dosage could lead to adverse side effects or an unintended therapeutic response. She stated there was no negative outcome to the resident and that the nurse had rechecked the blood sugar before lunch and her blood sugar was 300. Record review of facility policy titled Medication Administration and documenting guidelines dated 04/06/2023 revealed the following in part: Medications are administered according to manufacturer's guidelines unless otherwise indicated by physician order. Verify labels accurately reflect the physician orders on the Electronic Medication Administration record prior to administering medications verify medication accuracy by checking the medication with the EMAR. Administer the medication according to the physician order.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety, for 1 of 1 refrigerator in the secure unit. The facility failed to ensure the refrigerator on the secure unit that was used for patient snack storage was clean and temperatures were being checked and recorded. These failures could place residents at risk for foodborne illness, compromised nutritional health status, and being served food items that may not be fresh, taste stale, or be contaminated. The findings included:In an observation on 5/5/26 at 12:09 pm in the secure unit lobby, there was a small refrigerator that was soiled with dried food, spilled punch in the bottom, dust and dirt, and the ice had built up in the top freezer portion, and it needed to be defrosted on the inside. On the outside it was covered in dust on the top of the refrigerator. There was no temperature logs attached and no evidence of daily temperatures being taken. In an interview and observation with the DON on 5/5/26 at 12:20 pm, she said the night nurses were responsible for cleaning the refrigerator and taking the temperatures. The temperature log was observed at the nurse's station for the month of May 2026, and it was blank. She did not know why it was not filled out. She said a potential negative outcome would be infection control concerns.Record review of the facility policy Frozen and Refrigerated Food Storage, dated was revised 11/16/2017, revealed the following [in part]: Policy: PHF/THC (Potentially hazardous/Time temperature control for safety) foods will be properly refrigerated or frozen to reduce the potential for food borne illness and maintain product integrity. These procedures are applicable to pantry refrigerators and freezers of nursing units, if food or supplements for resident consumption and contained in those refrigerators and/or freezers. Procedure:2. Refrigerator and freezer temperatures should be checked and logged a minimum of twice daily, once in the morning and once in the evening. The purpose of this is to be able to react quickly if a unit is having a problem. Temperatures must be recorded on the appropriate temperature log. Record review of the Food and Drug Administration Food Code, dated 2022, specified [in part]:4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 1 (Resident #70) of 3 residents reviewed for infection control.The facility failed to implement Enhanced Barrier Precautions for Resident #70 who had an Enhanced Barrier Precautions sign posted on her room door. This failure could affect residents and place them at risk for cross contamination and infections.The findings included:Record review of Resident #70's admission Record, dated 5/8/26 revealed a [AGE] year-old female with an original admission date of 1/21/23 with the latest admission date of 3/16/26. Her diagnoses included embolism and thrombosis of arteries of the lower extremities (blood flow to the legs is blocked) and cerebral infarction (stroke-blood clot in the artery in the brain). Record review of Resident #70's Quarterly MDS, dated [DATE] revealed the resident had a BIMS score of 14 (cognitively intact). Section M - Skin Conditions revealed the resident had a stage 2 pressure ulcer. Record review of Resident #70's Physician Order Summary, dated 5/8/26 revealed the following orders: A. Implement Enhanced Barrier Precautions per CDC guidance for: Wound to Right Ankle. Gown and gloves required for high-contact resident care activities, including but not limited to: Dressing, bathing, and personal hygiene Wound care Device care Toileting and incontinence care Transferring, or extensive physical contact Hand hygiene before and after all resident contact. B. Cleanse abrasion to right second toe with normal saline or wound cleanser every day. C. Cleanse abrasion to right great toe with normal saline or wound cleanser every day. D. Cleanse unstageable pressure injury to right outer ankle with normal saline/ wound cleanser, apply collagen powder with anasept wound gel or wound gel and cover with padded dressing daily. In an observation and interview on 5/5/26 at 9:20 am revealed RN C entered Resident #70's room to perform wound care. There was an Enhanced Barrier Precaution sign on the door, and personal protective equipment inside of the room. The Wound Care Nurse provided wound care without donning a gown. At the end of the procedure, the RN C said she forgot to put on a gown due to the resident being on Enhanced Barrier Precautions. She said a potential for the failure was that infection could spread. In an interview on 05/05/2026 at 9:45 am, the DON said it was her expectation for the staff to glove and gown when they provided care to residents who were on Enhanced Barrier Precautions. She said RN C said she forgot to put on a gown. She said the failure had the potential to spread infection. Record review of the facility's policy titled Infection Prevention and Control Program, dated as revised 11/6/24, stated [in part]:Policy Explanation and Compliance Guidelines:6. Enhanced Barrier Precautions. EBP was used in conjunction with standing precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. B. During high-contact resident care activities:*Wound care: any skin opening requiring a dressing.Gloves and gowns prior to the high-contact care activity.